HOSPITAL COST CONTAINMENT ACT OF 1977

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH

OF THE

COMMITTEE ON HUMAN RESOURCES

UNITED STATES SENATE

NINETY-FIFTH CONGRESS

FIRST SESSION

ON

S. 1391

TO ESTABLISH A TRANSITIONAL SYSTEM OF HOSPITAL COST CONTAINMENT BY PROVIDING FOR INCENTIVES AND RESTRAINTS TO CONTAIN THE RATE OF INCREASE IN HOSPITAL REVENUES, TO ESTABLISH A SYSTEM OF CAPITAL ALLOCATION DESIGNED TO ENCOURAGE COMMUNITIES TO AVOID THE CREATION OF UNNEEDED AND DUPLICATIVE HOSPITAL FACILITIES AND SERVICES, TO PROVIDE FOR THE PUBLICATION AND DISCLOSURE OF INFORMATION USEFUL TO THE PUBLIC IN MAKING DECISIONS ABOUT HEALTH CARE, TO PROVIDE FOR THE DEVELOPMENT OF PERMANENT REFORMS IN HOSPITAL REIMBURSEMENT DESIGNED TO PROVIDE INCENTIVES FOR THE EFFICIENT AND EFFECTIVE USE OF HOSPITAL RESOURCES, AND FOR OTHER PURPOSES

Part 2: APPENDIX

WASHINGTON, D.C.
MAY 24, 26; JUNE 17 AND 21, 1977

BANGOR, MAINE
JULY 6, 1977



Printed for the use of the Committee on Human Resources

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CONTENTS

Additional Statements Submitted for the Record

	Page
Alice M. Rivlin, Director, Congressional Budget Office, U.S. Congress	839
The American Association of Neurological Surgeons	908
American Federation of State, County, and Municipal Employees	923
American Mutual Insurance Alliance	946
American Nurses Association	956
American Protestant Hospital Association	967
American Psychiatric Association	978
American Public Health Association	985
American Society for Medical Technology	1021
American Society of Hospital Pharmacists	1035
American Society of Internal Medicine	1049
Alfred M. Bell and Associates	1055
Association of Rehabilitation Facilities	1063
Association of State and Territorial Health Officials	1067
Arizona Hospital Association	1071
The Catholic Hospital Association	1077
Chamber of Commerce of the United States	1087
Chicago Hospital Council	1105
Colorado Hospital Association	1118
Community Memorial Hospital, Staunton, Ill	1121
Community Service Society of New York	1132
Corry Memorial Hospital	1139
Detroit Osteopathic Hospital Corp	1141
Florida Hospital Association	1144
Georgia Hospital Association	1160
Health Research Group—Public Citizen	1167
Hospital Association of New York State	1189
Hospital Association of Pennsylvania	1303
Hospital Affiliates International	1348
Hospital Financial Management Association, Inc	1354
Hospital Financing Study Group, Washington, D.C	1366
The Kansas Hospital Association	1389
Kentucky Hospital Association	1395
Legislature of Michigan	1408
Leon Hamrick, M.D., State of Alabama	1411
Maryland Hospital Association	1419
Massachusetts Department of Public Health	1421
The Medical College of Pennsylvania	1426
Medical Society, county of Kings, N.Y	1431
Minnesota Hospital Association	1435
Missouri Hospital Association	1450
Montana Hospital Association	1456
National Association of Health Services Executives	1464
National Audio-Visual Association, Inc	1470
National Conference of State Legislatures (Martin Sabo)	1472
National Council of Community Hospitals	1476
National Council of Health Care Services	1506
National Health Law Program	1518
National Taxpayers Union	1536
Nebraska Methodist Hospital	1538
New Mexico Hospital Association	1545
Radiation Imaging Products Division	1549
Resurrection Hospital	1552

	Page
Scientific Apparatus Makers Association	1581
South Carolina Hospital Association	1585
South Dakota Hospital Association	1591
State of South Dakota (Governor Kneip)	1605
Texas Hospital Association	1634
Union County Hospital Association	1648
Union County Hospital Society	1654
United Mine Workers Health and Retirement Funds	1666
United Societies of Physiotherapists Inc	1681
Utah State Hospital Association	1690
Vermont Hospital Association	1696
Washington Business Group on Health	1706
Letter from Lawrence Hill, New England Medical Center Hospital	1790
Letter from Sherman Katz, attorney at law	1794
Letter from David Troob, Loeb Rhoades & Co	1798

APPENDIX

ADDITIONAL STATEMENTS SUBMITTED FOR THE RECORD

CONGRESSIONAL BUDGET OFFICE
U.S. CONGRESS
WASHINGTON, D.C. 20515

Alice M. Rivlin
Director

June 13, 1977

Honorable Edward M. Kennedy
Chairman
Subcommittee on Health and
Scientific Research
Senate Committee on Human Resources
Washington, D.C. 20510

Dear Mr. Chairman:

I am most pleased to respond to your request for an analysis of S. 1391, the Hospital Cost Containment Act of 1977.

The attached report contains, as you asked, our evaluation of the programmatic and financial implications of Titles I and II of the bill.

We hope this report will be useful to you and to the subcommittee, and that it will contribute to the debate on the very important issue of health care costs.

Sincerely,

Alice M. Rivlin
Director

Enclosure

THE HOSPITAL COST CONTAINMENT ACT OF 1977: AN ANALYSIS OF THE ADMINISTRATION'S PROPOSAL

PREPARED BY THE

CONGRESSIONAL BUDGET OFFICE

for the

SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH

June 1977

PREFACE

This analysis of the Administration's proposed Hospital Cost Containment Act of 1977 (S. 1391 and H.R. 6575) was prepared by the Congressional Budget Office at the request of the Subcommittee on Health and Scientific Research of the Senate Committee on Human Resources. It was written by William L. Dunn and Bonnie Lefkowitz under the supervision of Stanley Wallack and Robert D. Reischauer. The cost estimates were prepared by Jeffrey C. Merrill. The authors wish to acknowledge the research assistance of Mark Chandler, the secretarial assistance of Toni Wright and Norma Leake, and the editorial assistance of Mary R. Boo.

A forthcoming CBO paper, Federal Programs and Their Impact on Health Expenditures, examines the problem of rising health care costs in a larger context.

In accordance with the mandate of the Congressional Budget Office to provide objective and impartial analysis, this report contains no recommendations. Throughout the text the years referred to are fiscal years unless otherwise noted.

Alice M. Rivlin
Director

TABLE OF CONTENTS

	Page
Summary	ii
Introduction and Background	1
Chapter I: The Administration's Proposal to Limit Hospital Revenues (Title I)	6
The Administration's Proposal	6
Impact of the Administration's Proposal	11
Alternatives to the Administration's Proposal	22
Chapter II: The Administration's Proposal to Limit Hospital Capital Expenditures (Title II)	32
Background	32
The Administration's Proposal	36
Impact of the Administration's Proposal	39
Estimated Savings in Costs to Hospitals from the Administration's Proposal	46
Alternatives to the Administration's Proposal	49
Chapter III: The Interrelationships Between Titles I and II	54

SUMMARY

In the Hospital Cost Containment Act of 1977 (S. 1391 and H.R. 6575), the Administration has proposed to limit both the revenues and capital expenditures of nonfederal short term hospitals.

Hospitals have been singled out for strong regulation because the total amount paid for hospital care has grown steadily and because the cost per patient day has been increasing at double the rate of overall inflation. Under current policy, the amount paid for care in the hospitals covered by the Administration's proposal is expected to total $61.3 billion in 1978 and $104.0 billion by 1982.

Excessive increases in the amount paid for hospital care are thought to be caused by operating inefficiencies, unnecessary growth in the intensity of services provided each patient, and duplicative facilities. These problems result, in turn, from a lack of cost consciousness by physicians and patients and from the fact that the federal government and private insurance plans most often reimburse hospitals on a cost basis. There are no existing federal controls on the total amount paid for hospital care.

Capital spending by hospitals has been singled out along with total revenues because it increases the amount of care delivered and the cost per patient day. Under current policy, capital expenditures by the hospitals covered by the Administration's proposal are expected to total $8.0 billion in 1978 and $14.1 billion by 1982.

Currently, the primary mechanism to control hospital capital expenditures is the National Health Planning and Resources Development Act of 1974, which requires that by 1980 each state establish a certificate of need program to ascertain the need for major new hospital investments. Of the 32 states that have so far passed certificate of need laws, only five seem to be operating programs that are at all effective.

THE ADMINISTRATION'S PROPOSAL TO LIMIT HOSPITAL REVENUES (TITLE I)

The temporary authority in Title I of the Hospital Cost Containment Act of 1977 would place a ceiling on total inpatient revenues of nonfederal short-term hospitals. Including expected adjustments in the ceiling for admission increases, wage pass throughs and exceptions, the growth in total revenues would be limited to 10.6 percent in 1978 and 8.9 percent by 1981. Revenues in excess of the limits would have to be returned or, in the case of commercial insurers and self paying patients, set aside for use in the following year; they would otherwise be subject to a 150 percent excise tax. Some states would be allowed to continue operating their own hospital cost control programs. The bill specifies that recommendations for permanent reform of hospital financing shall be made by the Secretary of the Department of Health, Education, and Welfare (HEW) by the beginning of March 1978.

Adjustments in the revenue ceiling could be made fairly automatically for small to moderate changes in the volume of admissions. Those hospitals with substantial changes in admissions or major changes

in capacity or type of service approved by the state agencies that review capital spending, could apply to a federal board for exceptions to the ceiling. A hospital would have to show that the increase in its costs would, without an exception to the revenue ceiling, force it into the lowest 25 percent of all hospitals in terms of ability to pay current liabilities. Upon a hospital's request, increases in the wages of nonsupervisory employees could be passed on automatically to payers. In this case the limit would be calculated only for revenues attributable to other costs.

The Administration's proposed revenue controls offer a number of major advantages. First, and most important, they would produce substantial cost savings as early as 1978, when total anticipated spending would be reduced $2.4 billion. These savings would grow rapidly in subsequent years, reaching $18.8 billion by 1982. Federal expenditures for medicare and medicaid would be reduced $1.0 billion in 1978 and $8.2 billion by 1982.

Second, the majority of savings would come from greatly reducing the growth in services, which is thought by many to be excessive and the most important source of increases in the amount paid for hospital care. Third, growth in admissions would also tend to decline since the proposal's volume adjustments are structured to encourage hospitals to treat fewer patients. This might address the problem of unneeded hospitalization, another source of cost increases.

Among the other advantages of the Administration's proposal are that it would be simple to administer and could be implemented immediately. In many ways it is the proposal's lack of complexity that leads to some of its shortcomings. While much of the following discussion concentrates on describing these disadvantages, it should be noted that all but one could be addressed by modifications that need not delay the proposal's implementation. Moreover, an approach similar to that taken by the Administration, placing a growth ceiling on the amount spent for care, appears to be the only way of significantly reducing the rapid rise in hospital costs.

The first problem with the Administration's proposal is that, while the growth ceiling should force many hospitals to become more efficient, there would be few specific incentives for efficiency. The only way efficiency would be rewarded would be to let hospitals whose revenues were under the ceiling carry over the surplus to the next year's limit. Because the Administration's proposal would restrict relatively fast growing hospitals, whether or not they are efficient, efficient hospitals might find it more difficult to live within the limit than rapidly growing inefficient ones.

Second, while there would be protection against a hospital's "dumping" patients because their insurance pays less relative to other types of reimbursements, there is no provision to prevent adverse selection by type of diagnosis. A hospital hard pressed by the limit could be tempted to admit more short-term cases that are inexpensive to treat and to direct expensive cases to other hospitals.

Third, the exceptions process would be limited to few hospitals in order to simplify federal administrative procedures. Thus it would

be difficult to deal with problems specific to a particular hospital or with unanticipated price increases that are not systemwide. Faced with such a situation, a hospital might cut back on services, including those needed by the community, such as emergency rooms and outpatient clinics, rather than run down its reserves so as to be eligible for the exceptions process.

Fourth, with only nine months' notice of the imposition of a growth ceiling, some hospitals might experience difficulty early in the proposed program because they will have already committed themselves to expenditures they would have avoided with more notice.

Fifth, hospitals and unions could cooperate in evading the growth limit by alternating a high wage increase that would be passed through in one year with no increase the following year. The second year hospitals could apply the full growth allowance for all revenues to nonlabor purposes.

Alternatives to Title I

Incremental changes can be made in the Administration's proposal or more distinct alternatives could be considered.

Incremental changes in the Administration's proposal would not deal with the issue of efficiency incentives directly, but could address the four other problems discussed above. Such changes include:

- Dividing hospitals into different classes based on their size and services provided and applying different growth ceilings to each. These changes would recognize the different roles of hospitals and help prevent adverse case selection.

- Broadening the exceptions procedure to increase its accessibility and relative sensitivity among hospitals. If it were assumed that more hospitals would apply for and receive exceptions, it might be appropriate to adjust the legislated limit downward. For example, instead of an 8.7 percent growth limit and an estimate of less than 1 percent for exceptions, there could be a 6.5 percent growth limit and an estimated 3 percent for exceptions. A broader exceptions procedure would permit the specific needs of individual hospitals to be treated more judiciously.

- Combining allowable growth levels for the first two years. For example, using the proposed formula, the legislated limit would be 18.8 percent over two years rather than 8.7 percent in the first year. This would allow hospitals that have already made plans for expansion to better prepare for the revenue ceilings.
- Making the wage pass through option mandatory for all hospitals. This would prevent hospitals and unions from cooperating to evade the growth ceiling. Alternatively, the pass through could be eliminated.

A major alternative to the Administration's approach is the Medicare-Medicaid Administrative and Reimbursement Reform Act of 1977 proposed by Senator Herman Talmadge (S. 1470 and H.R. 7079), which includes an attempt to improve basic hospital efficiency rather than to impose a growth ceiling on the industry. Only medicare and medicaid reimbursements would be affected, rather than all hospital revenues, and the proposal would focus only on routine costs -- the 30 percent of total hospital costs attributable to room, board, and some salaries. An average for routine costs would be established for each type of hospital; hospitals would be paid bonuses if they were below the average, and any routine costs in excess of 120 percent of the average would be disallowed.

Since the Talmadge proposal would require a uniform cost reporting system, it could not be implemented before 1981. Medicare and medicaid savings from these provisions of the Talmadge proposal would be between $100 and $400 million in 1982. Cost savings under this approach are low compared to the Administration's proposal but they could be increased by reducing the bonus payments or the 120 percent limit.

The Talmadge and Administration proposals could be integrated so as to retain the advantages of both. If the Administration's revenue controls or a similar program were implemented in 1978, immediate cost savings would result. As soon as there were sufficient data to differentiate among hospitals and types of costs, a method similar to that of the Talmadge proposal could be used to control routine costs of all payers. Routine costs are believed to be most susceptible to efficiency incentives because they are under the control of hospital administrators. A growth ceiling could then be applied to nonroutine costs, in which the greatest growth is occurring.

THE ADMINISTRATION'S PROPOSAL TO LIMIT HOSPITAL CAPITAL EXPENDITURES (TITLE II)

Title II of the Hospital Cost Containment Act of 1977 would provide permanent limits on both capital expenditures by hospitals and beds per 1000 population. Beginning in 1978, no more than $2.5 billion could be approved nationwide each year for capital expenditures. For the first two years, this limit would be allocated among the states on the basis of population; in subsequent years, other factors could be considered. A standard of no more than 4.0 beds per 1000 persons and at least 80 percent aggregate bed occupancy would be established for each of the nation's 212 health service areas. In areas meeting both bed and occupancy criteria, no certificate of need could be issued for a project that would force the area out of compliance. In areas not meeting both criteria, a certificate of need resulting in additional beds could be issued only if twice as many existing beds were eliminated from the area as a whole.

95-195 O - 77 - pt. 2 - 2

In states without a certificate of need program, the limit would be enforced through Section 1122 of the Social Security Act. The federal government -- with the advice of states -- could disallow medicaid and medicare reimbursement for 10 times the amount attributable to depreciation and interest for a disapproved expenditure.

The Administration's proposal would address the overall problem of continued growth in capital spending by means of a substantial but delayed cut. Because previously approved construction projects will continue to affect capital outlays for up to three years, the ceiling would result in reducing the $8.0 billion in 1978 capital spending anticipated under current policy to only $6.5 billion. By 1982, however, a level of $4.6 billion could be expected instead of the $14.1 billion that would otherwise occur. Very roughly, these reductions in capital spending would translate into cost savings to hospitals of $780 million in 1978 and $15.1 billion by 1982.

While the Administration's capital expenditure controls would be quite successful in reducing future investment, five problems would remain.

First, the $2.5 billion limit is not based on an evaluation of need and could restrict necessary and possibly cost saving improvements in future years. Similarly, distribution of the limit by population, though used only in the first two years, might not reflect states' relative need for spending.

Second, while only 17 of the nation's 212 health services areas could build additional hospital beds, the proposal would be less successful in addressing existing excess capacity -- estimated by some at close to 100,000 beds -- or maldistribution. The areas that could expand capacity would nearly all be in the east, primarily because of the effect of the occupancy standard. The other 195 areas that would have to eliminate two beds to add one might simply maintain the status quo. In that case, no shrinkage of the existing system would occur and it would be difficult to reallocate resources.

Third, with tight restrictions on new beds, nearly all new spending would be for plant modernization and equipment, for which it has been difficult to determine need and ultimate cost.

Fourth, strict controls on new services could force some in-hospital procedures outside the hospital, where they could proliferate in volume.

Fifth, small investments under the review threshold of $100,000 would not be controlled and, especially if revenue controls were not enacted, could begin to grow at a faster rate.

Alternatives to Title II

In view of the record of current efforts to control hospital capital expenditures, the Administration's proposal, or similar steps, may be the only way to substantially reduce and redirect the system.

However, such actions would entail many of the risks of regulation, including inflexibility and the elimination of new competition. The following incremental changes could minimize some of the unresolved problems.

- If one believes that the dollar amount of the proposed ceiling is arbitrary and not related to need, it could be increased now or in the future. Alternatively, an exceptions system could be established that would allow any expenditures in excess of the $2.5 billion ceiling to be targeted on needed renovation and investments that offer future cost savings.
- The imposition of any ceiling would be facilitated by establishing a multifactor distribution formula immediately, rather than relying on population alone in the first two years.
- Excess capacity and maldistribution might be addressed more effectively by requiring a lower bed to population ratio in five years and penalizing hospitals and health service areas for any excess capacity. Direct payments could be provided to relieve hospitals of the costs of eliminating beds.

RELATIONSHIP OF REVENUE CONTROLS AND CAPITAL EXPENDITURE CONTROLS

Titles I and II are integrally related and reinforcing. Reductions in capital investment would result in lower operating costs, which should make it easier for hospitals to live within the revenue limit. Because of this interrelationship, the specific limits of the proposal must be consistent. The administration of Titles I and II must also be coordinated. Because states would be the primary administrators of the capital expenditure controls, it may be desirable for them to participate more actively in the federal revenue control program. Even if states did not operate their own cost control programs, they could administer an expanded exceptions process similar to that described as an incremental change in Title I.

CHAPTER I. INTRODUCTION

The Administration's proposed Hospital Cost Containment Act of 1977 (S.1391 and H.R. 6575) would sharply reduce projected increases in the operating revenues and capital expansion of most short-term care hospitals. Title I of the bill would limit to about 10.6 percent the total increase in hospital operating revenues from inpatient care in 1978; Title II would reduce capital spending for the year to $6.5 billion, with greater decreases in the future. Without these controls, hospital revenues are expected to rise by about 15 percent and capital spending to total about $8.0 billion. While the provisions of Title I are labeled "transitional," Title II is intended to provide permanent amendments to existing regulatory efforts.

Short-term hospitals have been singled out for strong regulatory action because of sustained growth in the total amount paid for their services and because the annual increase in the cost of an inpatient hospital day continues to be double the rate of overall inflation. The amount spent for hospital care has increased as a proportion of total health expenditures from about 30 percent in 1950 to almost 40 percent today. By 1981 hospital care costs are expected to account for over 43 percent of total health expenditures.

The amount spent for hospital care has risen because of increases in cost per patient day and in the number of hospital days. The former factor is much more important, accounting for about 90 percent of the increase. Over the past 25 years, the cost of the average day in a

hospital has gone up ten-fold. Nevertheless, the demand for hospital care has not abated. A major reason for this is the growth in health insurance payments, which now account for 91 percent of all hospital revenues. This high level of third party payments has created a situation in which none of the participants involved in determining the level and type of hospital care -- the patient, insuring agent, physician or hospital administrator -- has an overriding interest in or need to control either per unit costs or total expenditures.

The patient has limited ability to distinguish necessary from unnecessary care. Once in a hospital, he has a strong interest in receiving the best care available. The pervasiveness of insurance coverage has meant that the cost of treatment is of little concern. The insuring agent has usually chosen not to question the value of or need for the services provided. The physician, who acts on the patient's behalf, is inclined to use all the services that will improve his diagnosis and therapy or reduce the possibility of malpractice suits. The hospital administrator is concerned that the quality of care be of a high standard and that his facilities and equipment be such as to attract physicians to the hospital. The administrator is therefore willing to meet physicians' requests to expand the scope and complexity of the services that their institutions provide. This entails little financial risk for the administrator because the majority of hospital insurance payments are based on the costs incurred. If costs rise because of new or more intensive testing, more complex procedures, or more staff, higher reimbursements will be forthcoming.

This unique set of characteristics has encouraged the following hospital and communitywide inefficiencies in the use of resources:

- o Uneconomic hospital operation. Inefficiency occurs when the combination of resources used to provide hospital services is more costly than necessary.

- o Uneconomic provision of services. Inefficiency occurs when services are provided that cannot reasonably be expected to have a medical value that justifies their cost.

- o Excess community capacity to provide general care. Even a carefully operated hospital may be relatively uneconomical if demand is low relative to capacity.

- o Excess community capacity to provide various forms of special-purpose care. An otherwise economically run hospital may have a special facility that is underutilized because other hospitals in the area have developed the same capability.

- o Excessive utilization resulting from the existence of excess hospital facilities or equipment. Unnecessary hospital admissions and utilization of procedures and equipment may be stimulated by the availability of capacity because no participant is motivated to be cost conscious.

To remedy these problems hospitals must be induced by statute, financial incentives, or public pressure to behave differently. In general, the first two problems show promise of responding to changes in the reimbursement system since both are internal to the hospital. On the other hand, reimbursement pressures on hospitals to correct for underutilization may induce an increase in unnecessary care; therefore, reimbursement practices need to be coordinated with communitywide planning and investment decisions if the last three problems are to be addressed.

The Administration's proposal would place a limit on the operating revenues of hospitals, with the effect that hospital administrators could no longer expect a level of revenues equivalent to costs. The extent to which hospitals would be able to keep their costs in line with the revenue limits would depend on the decisionmaking process within hospitals and on how effective administrators were in gaining the cooperation of physicians, who decide on the level and complexity of care. There is nothing in the Administration's proposal that would necessarily induce physicians to alter their current behavior in the utilization of resources. If physicians did not cooperate, hospital administrators might be forced to cut back on expenditures for community services, which they do control, to stay within the revenue limits.

The Administration's proposal would also impose two new types of capital controls -- a nationwide dollar limit on new capital expenditures and standards for the number of hospital beds and their rate of occupancy. The expenditure ceiling, which would be distributed among states for allocation to individual hospital projects, would significantly reduce hospital capital outlays and, thereby, could lower future hospital costs. The response of the state and local agencies that would allocate the ceiling among hospital projects would determine whether the types of investments made within the ceiling are beneficial.

This paper analyzes the two elements of the proposed Hospital Cost Containment Act of 1977. Chapter I describes Title I, the revenue limitation proposal, evaluates its major features and presents possible

alternatives to the Administration's approach. These alternatives include the approach proposed by Senator Herman Talmadge in the Medicare-Medicaid Administrative and Reimbursement Reform Act of 1977 (S. 1470 and H.R. 7079), which would deny federal reimbursements for unusually high routine hospital costs. 1/ Chapter II discusses Title II, the limitation on new investments, evaluates its major features and presents some alternative approaches. Chapter III discusses the reasons for considering Titles I and II together rather than as separate proposals.

1/ For a more thorough analysis of alternative reimbursement reforms and the growth of health expenditures, see Federal Programs and Their Impact on Health Expenditures, CBO Background Paper (forthcoming).

CHAPTER I THE ADMINISTRATION'S PROPOSAL TO LIMIT HOSPITAL REVENUES (TITLE I)

THE ADMINISTRATION'S PROPOSAL

The Administration has proposed in Title I of the Hospital Cost Containment Act of 1977 to place a growth ceiling on the total inpatient revenues received by short-term care hospitals (those with an average length of stay of under 30 days) beginning October 1, 1977. Revenues of federal hospitals, hospitals that derive over 75 percent of their patient care revenue from health maintenance organizations (HMOs), and hospitals that are less than two years old would not be limited by the growth ceiling. The proposal is viewed as transitional and would require the Secretary of the Department of Health, Education, and Welfare (HEW) to submit his recommendations for a permanent remedy by March 1, 1978.

The revenue limit would be applied separately to each type of payer: cost payers such as Blue Cross, medicare, and medicaid; and, a single class known as charge payers that includes commercial insurers and self-paying patients. This would avoid disadvantaging patients of cost payers, who have traditionally negotiated a lower rate with hospitals. The proposal would also require that hospitals maintain their share of charity patient admissions.

Ceiling on the Rate of Growth of Total Revenues

For 1978 the growth ceiling for individual hospitals would be 8.7 percent. The growth ceiling for each year would be determined by a formula containing both an inflation component and a separate allowance for real growth. Because the proposal is intended to deter increases in the number of patients treated, this growth component is considered to be an allowance for increases in the intensity or real level of services provided per admission. The inflation component would be based on the annual percentage change of the Gross National Product (GNP) deflator over the 12 months prior to the end of June in the year in which the control period starts. The intensity component would be equal to one-third of the difference between the percentage increase in total hospital expenditures and the increase in the GNP deflator for the two calendar years prior to the year in which the control period begins. The computation for fiscal year 1978 is shown below:

	Inflation Component		Intensity Component
Growth Ceiling 1978	= GNP deflator		+ 1/3 (Total hospital expenditures minus GNP deflator)
	(Percentage change 1976-III through 1977-II)		(Percentage change from Jan. 1975 through Dec. 1976)
8.73	= 5.52		+ 3.21

If the Secretary of HEW determined that the rate of increase in the GNP deflator during the control period would be more than 1 percent greater than that computed in the inflation component of the formula, the growth ceiling could be increased.

The limit on total revenues would not be a substitute for existing reimbursement systems; rather, it would be imposed on the existing structure. Hospitals would still be reimbursed on the basis of costs or charges depending upon the method used by the payer. However, both the hospital and intermediaries would be restricted from increasing total hospital revenues by more than the growth ceiling. For example, in the case of reimbursement from a cost payer, if a hospital's costs rose 7 percent, it would get 7 percent greater revenues from the payer but could carry forward the unused 1.7 percent from the 1978 revenue limit. If costs rose 11 percent, the hospital would receive only an 8.7 percent revenue increase from that payer and revenues in excess of the limit would have to be returned to the payer. In the case of charge payers, excess revenues would have to be set aside in an escrow account and applied against the following year's allowable level. Failure to follow these procedures could result in a 150 percent excise tax on the excess revenues.

Adjustments in the Growth Ceiling for Changes in Patient Volume

For increases up to 2 percent and decreases up to 6 percent in the number of patients admitted to a hospital during the year, there would be no change in the revenue limit. However, to allow for more substantial changes in the number of patients admitted, a volume adjustment to the total revenue limit is included in the proposal. For each increased admission between 2 and 15 percent, a hospital's total revenue could be raised by 50 percent of the base period's average revenue per

admission. 1/ Increases over 15 percent would not be reimbursed in large hospitals; in smaller hospitals, the allowance would continue without a cut off because admissions to such hospitals are subject to more variation. 2/

A similar type of volume adjustment would be applied to decreases in admissions. For each decreased admission between 6 and 15 percent, a hospital's total revenue would be reduced by 50 percent of the base period's average revenue per admission. In large hospitals, decreases beyond 15 percent would mean a reduction of the full average revenue per admission. The revenue limit for small hospitals would not be changed for decreases in admissions of less than 10 percent; beyond 10 percent, total revenue would be reduced by 50 percent of the average revenue per admission.

Optional Wage Pass Through

Hospitals could elect to have their limits on revenue increased to the sum of the actual percentage increase of nonsupervisory personnel wages weighted by this input's share of total costs, plus the formula-determined growth ceiling weighted by the remaining share of total costs. Therefore, for 1978 if nonsupervisory workers accounted for 25 percent of total costs and their wages rose by 16.0 percent, the revenue limit would be 10.5 percent (.25 x 16.0% + .75 x 8.7%) rather than 8.7 percent.

1/ Fifty percent of average revenue is believed by the Administration to be an adequate measure of the added cost per admission.

2/ Smaller hospitals are defined as those with fewer than 4,001 admissions annually in the base period.

Appeals for an Exception from the Growth Ceiling

In addition to the fairly automatic adjustments that have been described, a federal review board could increase a large hospital's revenue limit if admissions increased or decreased more than 15 percent, or if there were changes in hospital capacity or services that increased costs by more than the intensity component of the growth ceiling (3.2 percent in 1978). Changes in admissions, capacity, or services would have to have been approved by the state certificate of need or Section 1122 review agency. In order to appeal, the appellant hospital's ability to pay its current liabilities after the change (as measured by the ratio of its current assets to liabilities) would have to be in the lowest 25 percent of all hospitals included in the revenue limit. 3/ Financial distress alone would not be a sufficient basis for appeal.

A successful appeal based upon admission changes alone would result in treatment of the large hospital as a small hospital in calculating the volume adjustment. A successful appeal based on changes in service or capacity would result in raising the revenue limit, but only

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3/ This ratio is the sum of cash notes and accounts receivable (less reserves for bad debts), marketable securities and inventories held by the hospital divided by the sum of its liabilities falling due in the accounting year for which the exception is requested. A preliminary estimate, derived by the Administration from American Hospital Association data, is that this ratio is higher than 2 to 1 for 75 percent of the hospitals subject to the revenue limit.

The Administration has not determined whether the standard would be a fixed ratio or a ratio that declines over time as the financial condition of hospitals worsens as a consequence of the revenue limit. In the latter case, the criterion would be increasingly stringent.

by the amount needed to increase the hospital's asset to liability ratio to a level where it is no longer in the lowest 25 percent of hospitals included in the revenue limit.

Nonfederal Rate Setting Under the Administration's Proposal

The proposal would not preclude states or payers from operating their own cost control programs concomitantly with the federal controls. However, nonfederal programs could be substituted for the federal program only in certain situations.

State cost containment programs could be substituted if the state's governor ensured that the federal revenue limit would be met and that procedures for recovering excess hospital revenues and returning them to the payers would be established. The state cost containment program would have to have been in operation for at least one year before the application for a waiver from the federal program and would have to have included 90 percent of the hospitals in the state and 50 percent of all hospital inpatient revenues. The state would have to include 100 percent of inpatient revenues once it received a waiver to substitute its own controls for the federal program. Hospitals in prospective reimbursement demonstrations approved by the federal government -- whether or not all the hospitals in the state participate -- could be exempted without meeting these conditions.

IMPACT OF THE ADMINISTRATION'S PROPOSAL

There are a number of major advantages to the Administration's proposal, the most important being that it would result in substantial savings in the amount paid for care in nonfederal short-term hospitals as early as 1978. These savings would grow rapidly in subsequent years,

with an increasing proportion coming from reduced growth in the intensity of services. Growth in hospital admissions would probably decline as well, because the proposal contains strong incentives for most hospitals to treat fewer patients.

The Administration's approach would be simple to administer and could be implemented immediately. In many ways it is the proposal's very simplicity that creates some of its shortcomings. While a great deal of the following discussion concentrates on describing these disadvantages it should be noted that most of them could be addressed through modifications in the Administration's proposal. In addition, an approach similar to that taken by the Administration, placing a growth ceiling on the amount paid for care, may be the only way of significantly reducing the rapid rise in hospital costs.

Among the proposal's disadvantages are the following: First, it would do little to reward efficiency, and in some cases, would penalize past efficiency. Second, the proposal would not distinguish well among types of hospitals and the mix of patients they serve. Third, the exceptions process would be quite restricted and its remedies fairly limited. Fourth, the ceiling could be applied too abruptly for hospitals to cut back on growth commitments. Fifth, the optional wage pass through may raise costs and may not be an effective way to protect hospital workers. Sixth, the measure chosen to reflect inflation in the growth ceiling formula is not a good index of the price increases facing hospitals. Both the advantages and disadvantages of the Administration's proposal are discussed in greater detail below.

Estimated Savings in Expenditures for Hospital Care

If existing policies continue, total expenditures for nonfederal short term hospitals are expected to be $61.3 billion in 1978 and

$104.0 billion by 1982 (see Table 1). If the Administration's proposal were implemented in 1978, including expected adjustments for admission increases, wage pass throughs, and exceptions, these expenditures would be limited to $58.9 billion, a 10.6 percent increase over the 1977 level. The nation's hospital care bill would be $2.4 billion lower than otherwise expected and federal payments for medicare and medicaid would be reduced by $1.0 billion.

Table 1. ESTIMATED IMPACT OF THE ADMINISTRATION'S PROPOSED GROWTH CEILING ON NONFEDERAL SHORT-TERM CARE HOSPITAL REVENUES, FISCAL YEARS 1978-1982 (Dollars in Billions) a/

	Current Policy		Under Administration's Proposal			
Fiscal Year	1. Rate of Growth	2. Expenditures for Hospital Services b/	3. Growth Ceiling	4. Growth Ceiling + Expected Increases d/	5. Expenditures for Hospital Services	6. Savings due to Growth Ceiling
1978	15.1%	$61.3	8.7% c/	10.6%	$ 58.9	$2.4
1979	14.0	69.8	9.3	11.2	65.5	4.3
1980	14.1	79.7	7.6	9.5	71.8	7.9
1981	14.0	90.8	7.1	9.0	78.2	12.6
1982	14.5	104.0	7.0	8.9	85.2	18.8
1978 to 1982	14.3%	$405.1	7.9%	9.8%	$359.6	$46.0

a/ Congressional Budget Office estimates. Entries do not sum to totals because of rounding.

b/ These figures are for only those hospitals that would be covered by the Administration's proposal. Total expenditures for hospital care without any new cost containment initiatives are estimated at $55.4 billion for 1976, $64.3 billion for 1977, and $73.9 billion for 1978.

c/ The growth ceiling for 1978 differs from the Administration's 9% projection because, at the time the Administration made its estimate, figures for calendar year 1976 hospital expenditures were not available.

d/ Column 4 is column 3 plus a 1.0 percent allowance for increases in admissions plus a 0.9 percent allowance for revenue increases due to the pass through of wage increases and to the exceptions process.

95-195 O - 77 - pt. 2 - 3

By 1982, under the Administration's proposal, expenditures for nonfederal short term care hospitals would rise to $85.2 billion, $18.8 billion lower than otherwise expected. Federal payments for medicare and medicaid would be reduced by about $8.2 billion. The total reduction in hospital revenues or savings expected from the Administration's proposal during the five year period 1978-1982 would be about $46.0 billion.

Decrease in Real Growth of the Hospital Industry

The Administration's proposal would probably have its most profound impact on the real growth (increases net of inflation) in hospital revenues because the intensity component of the limit is designed to decrease over time. 4/ This component depends each year on the two prior years' increase in total hospital expenditures. Since such expenditures are expected to be reduced by the proposal, subsequent allowances for increased intensity will also be smaller.

Since 1965, real growth in expenditures by hospitals has occurred at an average rate of almost 8.4 percent annually. Approximately 2.3 percent of the growth has been attributable to additional admissions and 6.1 percent to increased intensity. Under the Administration's proposal, the noninflation component would be about 3.2 percent in 1978 and would be reduced to less than 2 percent by 1982 (see Table 2).

4/ If admissions did not decrease, or if the inflation component underestimated the rate of increase in prices hospitals must pay for goods and services, very little would actually be left of the limit for increased intensity or real growth per admission.

Table 2. ESTIMATED COMPONENTS OF ANNUAL GROWTH IN THE ADMINISTRATION'S PROPOSAL, FISCAL YEARS 1978-1982 a/

Fiscal Year	Intensity Component (For Two Calendar Years Before Fiscal Year) 1. Total Hospital Expenditures b/	2. GNP Deflator	3. Allowance for Intensity c/	Inflation Component (12 Months Prior to June of Previous Fiscal Year) 4. GNP Deflator	5. Growth Ceiling d/
1978	15.51	5.87	3.21	5.52	8.73
1979	14.91	5.55	3.12	6.22	9.34
1980	12.65	6.00	2.22	5.40	7.62
1981	11.50	5.39	2.04	5.02	7.06
1982	10.98	5.12	1.95	5.06	7.01

a/ Congressional Budget Office estimates.

b/ Those hospitals not included in the cost containment program are assumed to increase their expenditures by 14.0 percent per year. While the proposal excludes new hospitals and those whose primary source of revenue is from HMOs, these estimates did not adjust for their exclusion because of their insignificant effect.

c/ Column 3 is one-third of the difference of Column 1 less Column 2.

d/ Column 5 is the sum of Columns 3 and 4.

Decrease in Admissions

Because revenue per admission increases as the volume of admissions is cut back, a strong incentive to treat fewer patients would be created by the Administration's proposal. If a large hospital reduced the volume of patients treated up to the threshold of 6 percent, total revenues allowed would remain the same and revenues per admission would be increased (see Table 3). If volume were reduced between 6 and 15

percent, the hospital's income would be decreased by only 50 percent of the base period's average revenue per admission. Therefore, at 85 percent of the base year's volume, a hospital could receive 123 percent of the base period's revenue per admission. Even reductions in admissions beyond 15 percent would allow for an increase in revenues per admission.

Table 3. TOTAL REVENUES AND REVENUE PER ADMISSION UNDER THE ADMINISTRATION'S PROPOSAL, AT VARYING LEVELS OF ADMISSIONS (All Figures Expressed as a Percent of the Base Year)

Annual Admissions	Potential Total Revenue	Potential Revenue Per Admission
	Hospitals Over 4000 Admissions	
60	79	132
85	104	123
94	109	116
100	109	109
102	109	107
115	115	100
150	115	77
	Hospitals Under 4001 Admissions	
60	94	156
90	109	121
94	109	116
100	109	109
102	109	107
115	115	100
150	133	88

Small hospitals could reduce volume by 10 percent without lowering their total revenue limit, and further reductions in volume, no matter how great, would result in a decrease of 50 percent of the base period's average revenue per admission. Thus a small hospital would be eligible to receive up to 121 percent of revenue per admission when it is at 90 percent of the base period's volume and 156 percent of revenue per admission at 60 percent of the base period's volume.

These incentives would of course be limited not only by the hospital's operating costs, but by its desire to maintain its patient volume relative to other hospitals, its concept of service to the community, and the behavior of its physicians. Most hospitals would probably attempt to reduce admissions slightly or to avoid increases in admissions.

Lack of Rewards for Efficiency

A major problem with the Administration's approach is that it does not significantly recognize different levels of efficiency among hospitals. The only way the proposal would reward efficient behavior would be to let a hospital whose revenues were less than those allowed add the difference to its next year's limit. Other types of efficiency incentives would require more reliable and uniform reporting of hospital costs than is currently available.

The revenue ceiling should force many hospitals to operate more efficiently. However, without more specific incentives, hospital administrators might not be able to withstand pressure from physicians

to continue inefficient practices. Moreover, fast growing hospitals would be most affected by the Administration's proposal, whether or not they were efficient. Because efficient hospitals may have already sought the obvious economies, they could find it more difficult to reduce their growth rates than inefficient hospitals with a lot of slack in their operations.

Adverse Selection of Patients

The Administration's proposal could induce some hospitals to admit more patients that are inexpensive to treat, such as simple surgery cases and candidates for diagnostic testing, and to direct expensive cases elsewhere. Some expensive cases might be referred to teaching hospitals, and others might end up in county and municipal hospitals that have no choice in the patients they accept. While there would be some protection in the Administration's proposal against a hospital's "dumping" charity patients and patients whose insurance pays less relative to other types of payers, there is no provision to prevent adverse selection by type of diagnosis. 5/ Neither would the proposal recognize this tendency by allowing higher growth rates for the hospitals that must treat additional expensive cases.

5/ Approximately 200 Health Systems Agencies established nationwide by the Health Planning and Resources Development Act of 1974 would be responsible for enforcing the maintenance of the charity patient provision when complaints were received from hospitals, presumably mostly county and municipal, which would have to treat those refused by the others. However, the hospitals that might be expected to complain are those that pay less attention to the insurance status of their patients. Moreover, Health Systems Agencies have little experience in such enforcement.

The volume adjustment provided in the Administration's proposal could also affect patient mix under certain circumstances. While most hospitals would tend to decrease the number of admissions or maintain their current volume, some of those already at 102 percent of their base year's volume might attempt to increase admissions further. This would occur if they could find cases that cost less to treat than the amount by which their revenue limits would increase -- 50 percent of the base period's average revenue per admission. To the extent that volume was increased by patients who would not have otherwise been hospitalized, the Administration's proposal would encourage behavior that increases expenditures.

Limited Nature of Exceptions Process

Under the Administration's proposal, the exceptions process would be limited to those hospitals with substantial changes in admissions or services that can also demonstrate financial distress. The process would clearly simplify federal administrative procedures, but it would be difficult to deal with problems specific to a particular hospital or with unanticipated price increases that are not systemwide. The stringency of the exceptions process might also lead to undesirable behavior on the part of hospitals. For example, a hospital might choose to cut back on services needed by the community, such as an emergency room or an outpatient clinic, rather than using up most of its reserves, which it would have to do before applying for an exception.

In addition to the fact that only a limited number of hospitals could apply for an exception, the remedies available under the Administration's proposal are not likely to be attractive to hospitals. The remedy for an increase in admissions greater than 15 percent, without an increase in capacity, would be to allow the hospital to receive 50 percent of average revenue per admission. When a hospital is operating close to capacity, this is probably substantially less than it costs to care for an additional patient. The remedy for a change in capacity or a change in the character of services would be to increase the hospital's revenue limit just enough to bring its current ratio of assets to liabilities up to the level where it would be disqualified from applying for an exception. Such remedies may provide relief that is less than the added costs incurred by the hospital.

Abruptness of Revenue Limit

The Administration's proposal might impose a particular hardship on hospitals that have already committed themselves to growth in capacity or intensity of services. The lead time for such commitments is often as great as three years. With only nine months' notice of a growth ceiling, hospitals may not be able to extricate themselves from commitments they would have avoided with more notice.

Adverse Effect of Optional Wage Pass Through

The wage pass through option offered in the Administration's proposal could undermine hospitals' resistance to large wage increases

for nonsupervisory personnel in two ways. First, the existence of the growth ceiling could lead unions and workers to expect wage increases equal to the limit. This would be greater than most past raises for such workers, which averaged 7.2 percent annually between 1969 and 1976.

Second, hospitals and unions could collaborate to escape the growth ceiling by arranging to have large wage increases every second or third year. In the year in which the wage increase was given, the hospital could request a pass through, making it indifferent to an increase that might be as great as 15 or 20 percent. In the other year or two when no wage increase was given, the hospital could select the standard method for calculating its growth limit and could use its entire revenue increase for nonlabor purposes.

Inadequate Measure of Price Inflation

Under the Administration's proposal, hospitals may not be well protected from increases in the cost of the goods and services they need to maintain their existing level of care because these increases are not well measured by the GNP deflator. Moreover, the use of past rates of inflation in the Administration's formula does not reflect current price increases. An adjustment could be made only if the most recent annual rate of increase reported for the GNP deflator is more than 1 percentage point greater than the rate used in the formula.

ALTERNATIVES TO THE ADMINISTRATION'S PROPOSAL

Both incremental changes and more distinct alternatives to Title I of the Hospital Cost Containment Act of 1977 exist. Those that represent minor modifications of the Administration's proposal could address most of the problems that have been raised above without delaying implementation. However, they would do little to promote efficiency, since the proposal is structured to control growth rather than to affect present hospital operations.

A distinct alternative is the Medicare-Medicaid Administrative and Reimbursement Reform Act recently introduced by Senator Herman Talmadge. The Talmadge proposal is directed at eliminating operating inefficiencies rather than containing the growth of hospital services. It would take several years to implement and would result in much smaller savings than the Administration's proposal. Approaches that combine the advantages of the Administration's proposal and the Talmadge approach could also be formulated.

Possible Modifications in the Administration's Proposal

Modifications in the Administration's proposal include grouping hospitals as to size and case mix before applying growth ceilings, broadening the exceptions process, combining allowable increases over the first two years, either making the wage pass through mandatory or eliminating it entirely, and using a more precise indicator of hospital costs than the GNP deflator.

Varying the Growth Limit Among Hospital Types. The Administration's proposal would create incentives for further concentration of patients with illnesses that are expensive to treat in teaching hospitals and those operated by county and municipal governments. It might therefore be desirable to recognize that such hospitals may need to grow at a faster rate. Hospitals could be classified according to the services they provide and different growth limits applied to each class. A further modification would require a more refined classification system but might also provide some incentives for efficiency by allowing each member of a class the same dollar increment rather than the same percentage increase in revenues. For example, if the average revenue for a specific class were $1000 per admission and the growth limit were set at 9 percent, all hospitals in that group would be permitted a $90 increment per admission over their previous year's revenues. For a hospital whose revenues were only half that of the average, this would represent an 18 percent increment; for a hospital whose revenues were 50 percent greater than the group average, it would be only a 4.5 percent increase. This approach would require a sufficient number of hospital classes so that those in each class were reasonably alike. It might also be necessary to group hospitals by region of the country to avoid imposing hardships on hospitals in high cost regions.

Broadening the Exceptions Process. The proposed exceptions process would be accessible only to those institutions that are expanding admissions, services, or capacity and are, at the same time, in relatively poor financial shape. There may be ways of making the exceptions

process more flexible, although this would entail more staff, either at the state or federal level. A more flexible exceptions process could delete the present proposal's financial distress requirement. In addition to restricting access to the process, this requirement may not be an appropriate screening device for determining whether expanded services should be reimbursed.

Broadening the exceptions process would not necessarily decrease anticipated savings. Since a more flexible and accessible exceptions process could reduce the danger of imposing hardship on individual hospitals, a revenue ceiling lower than that arising from the proposal's current formula could be set. For example, the revenue ceiling could be set at the inflation rate plus 1 percent (6.5 percent for 1978). Three percent could be set aside for exceptions, rather than the less than 1 percent the Administration has estimated for its proposal. Such a procedure might be more acceptable to the hospital industry since it would be less arbitrary.

Combining Allowable Increases Over the First Two Years. The imposition of a growth ceiling would penalize all high rates of growth, whether sustained or temporary. This may not be undesirable if capital outlays that the cost containment proposal seeks to discourage are responsible for sudden spurts in expenditures. However, if the growth in hospital outlays expected in 1978 reflects obligations and decisions that have already been made, hospitals may have very little ability to control immediate growth. A modification would be to combine the

growth allowed in hospital revenues over the next two fiscal years, achieving the same savings but giving hospitals a longer period in which to adjust. 6/

Making the Wage Pass Through Mandatory or Eliminating It. The growth ceiling could be calculated for each hospital on the basis of its actual wage increases, thus making the wage pass through mandatory. With this modification, a hospital could not squeeze wage increases in order to maintain other spending as it could with the standard method of calculation in the Administration's proposal. Thus a mandatory pass through would be more likely to protect nonsupervisory hospital employees. It would also eliminate the possibility that hospitals might cooperate with unions to avoid the growth ceiling by alternating large wage increases in one year with none in the next. If annual wage increases continued to average less than the growth ceiling, anticipated savings would be greater with a mandatory wage pass through than under the Administration's proposal. However, if the pass through were mandatory, there would be little reason for hospitals to resist wage increases and there could be a danger of larger increases. Some concern about future hospital wage levels could be retained by making it clear to hospitals that permanent reforms of hospital reimbursement might use a wage index based on area wages or average hospital wages rather than the hospital's actual wage level. Since the Administration's proposal would allow the Secretary of HEW to consider eliminating the

6/ The compound rate of growth for the two year period that would be allowed under the present proposal is about 18.8 percent.

wage pass through after 18 months, statements to unions that wage increases would have to remain in line with those for comparable employees in other industries to preserve the pass through might encourage restraint.

Alternatively, the pass through could be made mandatory only for those hospitals that choose it initially. Those hospitals not selecting the wage pass through would not have to report labor and nonlabor costs separately, and, as with the first alternative, the possibility of union-hospital collaboration to evade the growth limit would be eliminated. However, nonsupervisory hospital employees would be no more protected than with the present proposal.

Finally, the wage pass through could be eliminated. This would not protect hospital employees, particularly in geographic areas where wages are still low. However, the elimination would recognize that the wages of hospital workers in other geographic areas may no longer be out of line with nonhospital workers.

Improving the Measure of Inflation. While the consumer price index (CPI) would seem to be a better indicator of prices that a hospital must pay than the GNP deflator, the best alternative would be the construction of a separate hospital cost index. Such an index could be designed to reflect most accurately the price changes for the types of goods and services purchased by hospitals. Rate setting commissions in some states currently use a hospital price index in determining allowable increases in revenues.

The problem of using past rather than current measures of inflation could be remedied by using projected rates, such as those used in the President's Budget. An adjustment could be made at the end of the year or could be added to the next year's ceiling to compensate for any difference between the projected and the actual rate.

The Talmadge Proposal

The proposal introduced by Senator Talmadge in May 1977 is a distinct alternative to the Administration's proposal to control hospital costs. It would apply limits only to medicare and medicaid reimbursements and only to the 30 percent of those reimbursements attributable to room and board and some salaries which the proposal labels as routine. Under the Talmadge proposal, hospitals would be grouped by number of beds and type (short term general, teaching, and specialty hospitals). The average routine operating cost for each hospital group would be determined, and reimbursements to any hospital would be limited to 120 percent of its group's average cost. Bonus payments of up to 5 percent of routine costs would be awarded to a hospital that is below the average cost for its group.

The changes in hospital reimbursement called for in the Talmadge proposal would not take effect until 1981, when a uniform cost reporting system would be in place. The total reduction in federal expenditures for hospital care under medicaid and medicare might range from $0.1 to

$0.4 billion in 1982. 7/ While the Talmadge proposal would reward operating efficiency quite well, it would not assure reduction in the growth rate of expenditures by hospitals, even for routine services. If all the hospitals in a class became less cost conscious, the group average for routine costs of operation and the reimbursement limit would increase together.

If the Talmadge approach were applied to total hospital costs rather than to routine costs, savings might be lower because bonuses might increase more than penalties.

The savings generated by the Talmadge proposal could be increased if the limit on unusual costs were moved closer to the average cost. For example, if reimbursements were disallowed for routine costs in excess of 110 percent of the group average, rather than 120 percent, the cost savings might range from $0.2 to $0.8 billion in 1982. A limit set this close to the average cost for the group might cause substantial losses for some hospitals unless it were phased in even more slowly than anticipated by the Talmadge proposal.

7/ The range is wide because hospitals would have three years to prepare for implementation and it is difficult to predict changes in their behavior. The data on hospital costs used to estimate the savings were collected in 1973 during the Economic Stabilization Program and thus may not represent 1982 hospital costs very well.

Another option that could increase savings using the Talmadge approach would be to reduce or eliminate the bonus payments. Alternatively, the bonuses could be retained for hospitals with below average costs and only a part (perhaps a third) of that portion of hospital costs above the average could be reimbursed. There would then always be an incentive for a hospital to cut its costs. Under the current proposal, hospitals above the group's average but below 120 percent have no such incentive.

Still another way of comparing hospitals' costs rather than limiting their growth would be to have hospitals submit bids in advance for providing care. The bids would include all costs, not just routine costs, and could be implemented fairly quickly without a uniform cost reporting system. The only information required from hospitals would be the hospital's past volume and its estimated operating costs for the next fiscal year. Hospitals would be grouped as under the Talmadge proposal but their bids, rather than their actual costs, would be averaged and compared. A hospital with a bid below the group average would receive more than 100 percent of its bid for its interim payment; in other words, it would receive a bonus payment. Conversely, a hospital with a bid above the norm would receive a reimbursement rate below its bid -- or be penalized.

As with the Talmadge approach, the savings from this alternative would be quite low but efficiency incentives would be introduced. To assure that bids reflected actual costs, a retrospective adjustment of

95-195 O - 77 - pt. 2 - 4

the reimbursement rate could be made at the end of the fiscal year. This adjustment could also be varied according to the extent to which the hospital's actual cost differed from its original bid. 8/

Integrating the Administration and Talmadge Approaches

The Administration and Talmadge proposals could be integrated to retain the advantages of both. If the Administration's revenue controls or a similar program were implemented in 1978, immediate savings would result. As soon as there were sufficient data to differentiate among types of costs, the Talmadge approach could be applied to routine costs for all payers, rather than just for medicare and medicaid. The efficiency incentives of the Talmadge proposal are best applied to routine hospital operations, over which the hospital administrator has the greatest authority. The Administration's approach, which is directed at reducing growth in the intensity of services, could continue to be applied to nonroutine costs, for which the hospital administrator shares authority with the hospital's medical staff. In general, expenditures

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8/ The formula for determining the reimbursement rate could have two components, one which rewards hospitals for bidding low and penalizes high bids and another which rewards hospitals that hold their costs below their bid and penalizes those that do not.

$$\text{Reimbursement} = \text{Cost} \times \underbrace{\left[1 + \frac{\text{Avg. Bid} - \text{Bid}}{\text{Avg. Bid}}\right]}_{\text{Bid Adjustment}} \times \underbrace{\left[1 + \frac{\text{Bid} - \text{Cost}}{\text{Bid}}\right]}_{\text{Cost Adjustment}}$$

This option is discussed in more depth in Federal Programs and Their Impact on Health Expenditures, CBO Background Paper (forthcoming).

by hospitals for nonroutine services are the principal source of growth in the industry. Thus, both problems of hospital operation -- uneconomic hospital operation and uneconomic provision of services -- would be addressed by a combined approach.

CHAPTER II. THE ADMINISTRATION'S PROPOSAL TO LIMIT HOSPITAL CAPITAL EXPENDITURES (TITLE II)

BACKGROUND

Rising capital expenditures are an important -- some believe the most important -- source of hospital cost increases. These expenditures comprise about 13 percent of all spending by nonfederal short-term hospitals. If there is no change in current policy, they are expected to reach $8.0 billion in 1978 and $14.1 billion by 1982. The annual increases in capital expenditures have been slightly higher than those of total hospital spending, averaging 15.5 percent between 1970 and 1975. Approximately half of this increase, or 8.2 percent, is attributable to rising prices; the remainder reflects real growth in capital spending.

Consequences of Capital Expenditures

Most new capital spending is not considered a cost in itself; rather, it raises hospital costs in two ways. First, more than 80 percent of capital expenditures are paid for by borrowing, which adds to the hospital's annual debt service burden. Second, and more important, capital spending affects operating costs. While the precise relationship is not known, in the aggregate every dollar invested is thought to raise annual operating costs very roughly by 50 cents in subsequent years.

There are two types of capital expenditures -- those that change the type of service provided each patient, usually measured by plant assets per bed, and those that increase the capacity of the facility, usually measured by number of beds. Plant assets per bed in community hospitals increased from $21,300 to $34,500, or an average of 10.1 percent annually between 1970 and 1975. This first type of expenditure can either lower or raise operating costs. For example, better insulation could lead to lower fuel bills, or new laboratory apparatus could reduce the need for more costly manual analyses. On the other hand, new technology is often more expensive to operate than existing equipment and adds to the services provided each patient. A frequently cited example is the computerized axial tomography (CAT) scanner, a diagnostic device that costs roughly $500,000 to buy and can be expected to cost a hospital another $300,000 annually to run.

The second type of expenditure, an increase in bed capacity, almost always raises total operating costs. Nearly 100,000 community hospital beds were added between 1970 and 1975, increasing the total supply by an average of 2.2 percent annually and bringing the nationwide bed to population ratio to 4.4 beds per 1000 persons. Many health planners believe that a ratio of 4.0 beds, or less, per 1000 would be sufficient. If capacity is idle because it is greater than the demand for care, hospitals will operate inefficiently. This inefficiency is particularly pronounced in the hospital industry, where fixed costs represent approximately 60 percent of total costs.

Additional capacity can raise costs in another way because the number of days spent in the hospital and the volume of hospital-based procedures performed often increase with availability. This is related to the fact that physicians and their patients do not face the cost constraints found in most industries. Although individual hospitals may operate at a more efficient occupancy level in the presence of this induced demand factor, total hospital costs will be higher and the population may receive unnecessary care.

While additional costs to hospitals tend to be passed on in some form to consumers, hospitals may also use their assets or reduce their spending in an unrelated area to pay for a cost increase attributable to capital expenditures. Thus, a one-to-one relationship does not exist between capital expenditure-related cost increases and patient payments. A good case in point is debt service, which is not included directly in reimbursement rates. Reimbursements do include interest and depreciation, but the latter is often calculated on a larger base than that for which debt principal is owed, and it is figured over a longer period of time than the term of the debt.

The Effect of Current Federal Programs on Hospital Capital Expenditures

In the past, the federal government supported expansion of hospital capacity directly through construction grants (the Hill-Burton program). Expansion is still supported indirectly through guaranteed loans and the tax exempt nature of some bonds issued in behalf of nonprofit hospitals. Money raised through tax exempt bonds paid for more than 50 percent of all hospital construction outlays in 1976.

Only recently have steps been taken to control capital growth and reallocate resources. The primary regulatory mechanism is the National Health Planning and Resources Development Act of 1974, which requires every state to have a certificate of need program satisfactory to the Secretary of HEW no later than September 30, 1980, if the state is to continue to receive most federal health grants. Certificate of need agencies have approval power over proposals for new beds, services, and other capital expenditures in excess of $150,000. Thirty-~~one~~ two of the 50 states now have certificate of need statutes. Only five of these, all initiated before 1969 by the states themselves, appear to be at all effective. That is, available evidence indicates that they may reduce capital expenditures 5 percent annually, at the most, from otherwise anticipated levels. 1/

Another mechanism for controlling hospital capital expenditures was established by a 1972 amendment to the Social Security Act (Section 1122). This amendment provided for a similar state review process but with a $100,000 threshold and a federal sanction. If a capital expenditure is not approved, the amount attributable to depreciation and interest for that expenditure is disallowed from medicare and medicaid reimbursements. Seventeen of the ~~19~~ 18 states that do not have certificate of need statutes have Section 1122 agreements.

1/ Congressional Budget Office: Federal Programs and Their Impact on Health Expenditures, forthcoming.

Despite current efforts to control hospital capital expenditures, the following five types of problems remain:

- Growth is not being curbed rapidly or effectively enough because of the long lead time needed to establish a properly functioning review process and the political pressures on states to approve new projects.
- Excess capacity and maldistribution of hospital resources persist, primarily because most current programs control only new projects and cannot close or reduce existing facilities. Only a few states have moved tentatively to eliminate existing unneeded beds.
- In the absence of need and effectiveness criteria for new technology, state agencies have found it especially difficult to control non-bed expenditures.
- Many expenditures are under the $150,000 or $100,000 threshold and are therefore too small to be reviewed by certificate of need or Section 1122 agencies. Only a complementary system of reimbursement controls could affect these expenditures, and such a system is not yet in place.
- Hospital-type procedures performed outside a hospital are not controlled.

THE ADMINISTRATION'S PROPOSAL

In an effort to deal with some of these remaining problems, the Administration has proposed in Title II of the Hospital Cost Containment Act of 1977 two new types of permanent federal controls: a capital expenditure limit and bed and occupancy standards. New sanctions would be provided to help insure implementation.

Capital Expenditure Limit

The Administration has proposed that no more than $2.5 billion in new capital expenditures by nonfederal short term hospitals be approved by review agencies nationwide in any year beginning with 1978.

This limit would be allocated among the states on the basis of population during the first two years of the legislation. In subsequent years other factors, such as need for new facilities, construction costs, and condition of existing hospitals, might be considered in the allocation.

A state would specify the maximum expenditure by a hospital under each certificate of need issued and the total of these could not exceed the state's portion of the limit. Expenditures supported by charitable contributions and those made in non-hospital premises leased by the hospital would be included in the limit. Any part of a state's limit that was unused at the end of the year would be added to its limit in the subsequent year. A state's limit could be increased by the amount of unrealized depreciation on beds or facilities it closes. That is, if a hospital facility valued at $10 million when new were to close down after it had received $7 million in depreciation payments, the remainder, or $3 million, would be added to the state's capital expenditure limit.

Bed and Occupancy Standards

The Administration's proposal would also establish a standard of no more than 4.0 beds per 1000 persons and at least 80 percent aggregate bed occupancy for each of the nation's 212 health service areas. 2/ For hospitals in areas meeting both criteria, a certificate of need resulting in additional beds could be issued only if the area would be in

2/ The proposal does allow for the possibility that different ceilings and standards could be established for areas with special characteristics. Presumably places such as the health service area in Minnesota containing the Mayo Clinic would be included.

compliance with the criteria after the new project was completed. In areas not meeting both criteria, a certificate of need resulting in additional beds for an individual hospital could be issued only if twice as many existing beds were eliminated in the area as a whole. However, the two-for-one requirement would not apply to an individual hospital if no net increase resulted from its proposal to eliminate some beds and add others. 3/

New Sanctions

The Administration has proposed that in states without a certificate of need program, and in those where the certificate of need program does not yet include dollar limits on investment approvals, the limits would be enforced through Section 1122 of the Social Security Act, but with greatly expanded penalties. Unapproved capital expenditures would result in a penalty of ten times the amount attributable to depreciation and interest for those expenditures, applied against medicare and medicaid reimbursements. If the state has neither an acceptable certificate of need program nor a Section 1122 agreement, the Secretary of HEW would apply the Section 1122 sanctions directly. In all states, bonds would no longer be tax exempt if they supported bed increases that would force an area out of compliance with the standards, or for which a certificate of need had not been issued.

3/ It has not yet been determined whether the beds would have to be eliminated during the year that the certification is awarded, or at the time that the new beds were ready for occupancy.

IMPACT OF THE ADMINISTRATION'S PROPOSAL

The Administration's proposal would address the first and probably most pressing problem -- continued growth in capital spending -- with a substantial but partially delayed cut in allowable expenditures. The proposal would only partially address the problem of excess capacity and maldistribution, and it might exacerbate the third problem -- difficulty in reviewing non-bed expenditures. The proposed controls would not deal with the problem of hospital-type procedures performed outside the hospital. Neither would they cover small investments, although the revenue controls in Title I could do so.

Reduction in Capital Expenditures

If hospitals continued their current policies and the Administration's proposal were not adopted, capital expenditures requiring certificate of need or Section 1122 review would amount to $6.8 billion in 1978 (see Table 4). Additional capital expenditures that are too small to require review would raise total capital spending in 1978 to roughly $8.0 billion. If the Administration's proposal were adopted, the $2.5 billion ceiling would be applied to certificate of need and Section 1122 applications in 1978. However, its full impact would not be felt until 1981, because much of the capital spending during the next few years will be related to construction projects that were approved before 1978 but are not yet completed and in use. Thus, actual 1978 capital expenditures would be about $6.5 billion even with the Administration's limit in place. In 1981, when the full impact of the ceiling

Table 4. COMPONENTS OF HOSPITAL CAPITAL EXPENDITURES UNDER CURRENT POLICY AND THE ADMINISTRATION'S PROPOSAL, FISCAL YEARS 1978-1982 (Dollars in Billions)

		Current Policy					Administration's Proposal				
	1975	1978	1979	1980	1981	1982	1978	1979	1980	1981	1982
New beds a/	$1.2	$1.8	$2.1	$2.4	$2.8	$3.2	$1.8	$2.1	$2.4	--	--
Other construction and modernization b/	2.6	4.0	4.6	5.3	6.1	7.0	3.0	2.0	2.0	$2.0	$2.0
Equipment c/	.6	1.0	1.2	1.3	1.5	1.8	.5	.5	.5	.5	.5
Total requiring certificate of need or 1122 review	4.4	6.8	7.9	9.0	10.4	12.0	5.3	4.6	4.9	2.5	2.5
Not requiring certificate of need or 1122 review	.8	1.2	1.4	1.6	1.8	2.1	1.2	1.4	1.6	1.8	2.1
Total capital expenditures d/	$5.2	$8.0	$9.3	$10.6	$12.2	$14.1	$6.5	$6.0	$6.5	$4.3	$4.6

a/ Spending attributable to new beds is assumed to have been approved and initiated three years previously; the total expenditure is recorded for the year the project is completed.

b/ Spending for construction and modernization not attributable to new beds is assumed to take place as follows: one half of the projects are assumed to have been approved one year previously, with all of the expenditures for a particular project recorded the year the project is completed. The other half of the projects are assumed to have been approved in the same year that they are completed and recorded.

c/ Spending for equipment and technology is assumed to have been approved in the same year it is completed and recorded.

d/ All components of capital expenditures are based on 1975 estimates compiled by the Office of Research and Statistics, Social Security Administration. All components under current policy, and those components not controlled by the provisions of the Administration's proposal, are assumed to increase at the average annual rate of 15.5 percent that occurred between 1970 and 1975.

would be felt, capital spending would be $4.3 billion, $7.9 billion below the $12.2 billion anticipated without such controls. In 1982 spending would be $4.6 billion of an otherwise anticipated $14.1 billion.

One criticism that might be leveled against the Administration's proposal is that the magnitude of the cut is rather arbitrary, since it is not based on an evaluation of need for new capital expenditures. Once few or no new beds are being added, there may be an unmet need for modernization of outmoded facilities that exceeds the capital spending limit.

A second criticism that might be leveled is that allocation of the $2.5 billion ceiling among states on the basis of population is arbitrary, bearing little relation to differences in costs or to the states' relative need for replacing or improving facilities. Nationwide, the $2.5 billion would represent a reduction of about 70 percent from an anticipated level of $8.1 billion that would have been approved by state review agencies in 1978. With a distribution based on population, the amounts that could be approved by individual states would be very uneven in relation to anticipated levels. One state would be allowed to increase approved spending slightly despite the nationwide cut of 70 percent (see Table 5). Several others would be forced to cut back on approved spending by over 80 percent. While the population distribution might be replaced by a more judicious formula after two years, the shifts in levels resulting from changing formulas might pose a further problem to state agencies.

Table 5. HOSPITAL CAPITAL EXPENDITURES EXPECTED TO BE APPROVED BY CERTIFICATE OF NEED AND SECTION 1122 AGENCIES UNDER CURRENT POLICY AND ADMINISTRATION'S PROPOSAL, FISCAL YEAR 1978, BY STATE (Dollars in Millions)

	Current Policy a/	Administration's Proposal b/	Percentage Change
Total U.S.	$8,100.0	$2,500.0	-69%
Alabama	136.7	42.3	-69
Alaska	55.0	4.1	-93
Arizona	67.6	26.0	-62
Arkansas	53.4	24.8	-54
California	570.3	247.9	-57
Colorado	103.7	29.7	-71
Connecticut	165.0	36.2	-78
Delaware	34.6	6.8	-80
District of Columbia	99.0	8.4	-92
Florida	355.0	97.8	-73
Georgia	212.1	57.7	-73
Hawaii	23.6	10.1	-57
Idaho	14.1	9.6	-32
Illinois	535.7	130.4	-76
Indiana	92.7	62.2	-33
Iowa	92.7	33.6	-64
Kansas	94.3	26.5	-72
Kentucky	56.6	39.7	-30
Louisiana	158.7	44.4	-12
Maine	37.7	12.4	-67
Maryland	44.0	48.0	+9
Massachusetts	259.2	68.2	-74
Michigan	446.2	107.2	-76
Minnesota	132.0	45.9	-65
Mississippi	67.6	27.5	-59
Missouri	333.0	55.7	-83
Montana	40.8	8.8	-78
Nebraska	81.7	18.1	-78
Nevada	12.6	6.9	-45
New Hampshire	15.7	9.6	-39
New Jersey	237.2	85.6	-64
New Mexico	25.1	13.4	-47
New York	923.7	212.1	-77
North Carolina	80.1	63.8	-20
North Dakota	70.7	7.4	-90
Ohio	487.0	125.9	-74
Oklahoma	265.5	21.7	-88
Oregon	75.4	26.8	-65
Pennsylvania	419.5	138.4	-67
Rhode Island	28.3	10.8	-62
South Carolina	34.6	33.0	-5
South Dakota	23.6	8.0	-66
Tennessee	125.7	49.0	-61
Texas	328.3	143.2	-56
Utah	15.7	14.1	-10
Vermont	15.7	5.5	-65
Virginia	165.0	58.1	-65
Washington	138.2	41.5	-70
West Virginia	78.5	21.1	-73
Wisconsin	166.5	53.9	-68
Wyoming	11.0	4.4	-60

a/ Includes only those expenditures requiring certificate of need or 1122 review. The total of $8.1 billion is for sums expected to be approved in 1978 rather than those expected to be spent, and was derived from the current policy figures in Table 4 as follows: $2.8 billion for new beds is expected to be spent in 1981 and therefore would have been approved in 1978. One-half the spending for construction and modernization expected to occur in 1979, or $2.3 billion, would have been approved in 1978. One half the spending for construction and modernization expected to occur in 1978, or $2.0 billion, would have been approved the same year. All the spending for equipment expected in 1978, or $1.0 billion, would have been approved the same year. Distribution among states is based on each state's proportion of estimated capital expenditures in 1975 (data from American Hospital Association, Hospital Statistics, 1975 and 1976 editions).

b/ Assumes imposition of $2.5 billion ceiling on sums approved by certificate of need or Section 1122 agencies. Distribution based on relative population of states, July 1975.

Effects on Excess Capacity and Maldistribution

A ceiling of 4.0 beds per 1000 persons used alone would permit a total of 72 health service areas to expand capacity. 4/ These areas would be distributed fairly widely around the nation. The concomitant use of the 80 percent occupancy standard would curtail the number of areas allowed to expand capacity to only 17. The use of the occupancy standard could also have the effect of maintaining existing geographic disparities in supply and utilization. The 17 areas would be in nine eastern and two midwestern states, where occupancy rates are relatively high (see Table 6). While high occupancy rates are a measure of individual hospital efficiency, high rates for an area may also mean excess hospitalization for the population as a whole. Some indication of this may be found in the fact that the number of hospital days per 1000 persons also tends to be higher in eastern states.

Table 6. STATES AND NUMBER OF AREAS PERMITTED EXPANSION OF HOSPITAL BEDS

Using bed ceiling of 4.0 beds per 1000 plus 80% occupancy standard

Connecticut	(1)	North Carolina	(1)
Delaware	(1)	Ohio	(1)
Illinois	(1)	Pennsylvania	(1)
Maryland	(3)	Rhode Island	(1)
New Jersey	(2)	Virginia	(1)
New York	(4)		

4/ 1974 data on number of beds and occupancy rates in health service areas from HEW, Health Resources Administration. The number of areas affected by the standards could change if more recent data were available.

The use of an occupancy standard would be a greater problem if the capital expenditure title were approved by the Congress and the revenue control title defeated. If this occurred, there would be no countervailing pressure to decrease admissions, and areas with excess hospitalization would be encouraged to maintain current levels. There would be less tendency to actually increase admissions, since incentives to do so would exist at the level of the health service area rather than for individual hospitals.

A total of 195 health service areas would be held to the requirement of eliminating two beds before approving construction of, or actually adding, one new bed. If states intended to eliminate beds, they would probably have to establish decertification statutes and procedures and criteria by which to choose the targets for elimination. It would be especially difficult in a political sense to close hospitals or parts of hospitals if such institutions served not only a geographically defined area but particular religious, ethnic, or racial groups.

The two-for-one approach would assure control of expansion and, assuming that any new construction is to take place, savings would result fairly quickly from the closings. However, there is no assurance that beds would be eliminated. States might simply be unable to eliminate a sufficient number of beds, and do nothing. If no beds were eliminated, no additional cost savings or needed reallocations of resources would occur. A second problem with the two-for-one approach is that no allowance is made for areas that do not now meet the criteria but might in the future because of population growth. For example, a

rapidly growing area might have 4.1 beds per 1000 persons now, but by the time an approved expansion of capacity is in operation, the area would have 3.8 beds per 1000.

Shift in Type of Expenditure to Nonbed Investments

Because only 17 of the nation's 212 health service areas would be allowed to expand bed capacity, nearly all of the newly allocated capital limit would be spent on modernization and equipment. State agencies would be required to make decisions of the kind they have found most difficult in the past: choices between improvements needed to maintain an adequate level of service and increases in intensity that raise costs. An example of such a choice would be an inner city hospital's proposed modernization, on the one hand, and a suburban hospital's purchase of a CAT scanner, on the other.

Effect on Small Capital Expenditures

Under the Administration's proposal,the revenue controls of Title I would be relied upon to limit small capital expenditures. If these revenue controls were not enacted, reimbursements, including depreciation and interest payments in excess of debt service, could continue to generate slack in hospital budgets. In the presence of capital expenditure controls alone, hospitals could not spend this slack on major investments. Thus there would be strong incentives to increase smaller expenditures which, taken individually, are not large enough for certificate of need or Section 1122 review. It could be especially difficult to identify larger equipment purchases that were split into parts to keep them below the review threshold.

95-195 O - 77 - pt. 2 - 5

Effect on Nonhospital Procedures

Strict controls on new services within hospitals could force some services (for example, diagnostic procedures and simple surgery) outside the hospital. To the extent that a particular service could be provided more economically in a nonhospital setting, this would be a positive development. However, the absence of volume controls outside the hospital might lead to a proliferation of unneeded services. It would be more difficult to control the quantity of such services if they were performed in the offices of 250,000 physicians rather than in 6,000 hospitals.

ESTIMATED SAVINGS IN COSTS TO HOSPITALS FROM THE ADMINISTRATION'S PROPOSAL

The costs incurred by hospitals would be reduced in a number of ways by the Administration's proposal. First, the amount they spend from their own assets or on debt service for capital expenditures would be lower. Second, subsequent operating costs attributable to capital expenditures would also be decreased. It is important to note that these cost savings would not necessarily be passed on to consumers on a one-to-one basis. A third type of savings can result from decreases in the bed-to-population ratio, but this is not very likely to occur under the Administration's proposal.

Estimated Savings in Capital Spending

Cost savings to hospitals would occur to the extent that they did not spend their own assets on investments. Such assets are the source

of roughly 8 percent of all capital spending. Cost savings would also occur to the extent that hospitals' debt burden is reduced in future years. These savings could be substantial because debt financing is the source of roughly 80 percent of capital spending. 5/ The combined savings in capital spending would be approximately $410 million in 1978 and would increase to $4.35 billion by 1982 (see Table 7).

Estimated Savings from Reduced Operating Costs

It is more difficult to predict accurately the savings in operating costs that would result from reducing capital expenditures, especially since so little is known about the types of nonbed investments that would be made. If one assumes that the aggregate average ratio of hospital capital expenditures to annual operating costs remains at roughly 2 to 1, savings would be approximately $370 million in 1978 and $10.77 billion by 1982 (see Table 7). Total savings from reduced capital spending and operating costs would amount to $780 million in 1978 and $15.1 billion by 1982.

Estimated Savings If Enough Beds Are Eliminated

Further savings, in addition to those already estimated from reduced capital expenditures and operating costs, would result if enough beds were eliminated. If no beds were eliminated but a minimal number of new beds were approved, there would be no reduction in the bed to

5/ Estimates of the savings from capital spending do not include the 12 percent of such spending that originates outside the hospital but is not debt financed -- primarily philanthropy. However, estimates of savings from reduced operating costs do include this 12 percent because all capital spending, whatever its source, can be expected to influence the subsequent level of operation.

Table 7. ESTIMATED COST SAVINGS TO HOSPITALS RESULTING FROM ADMINISTRATION'S PROPOSAL TO CONTROL HOSPITAL CAPITAL EXPENDITURES, FISCAL YEARS 1978-1982 (Dollars in Billions)

	1978	1979	1980	1981	1982
Savings in capital expenditures a/	$ .41	$1.11	$1.84	$3.04	$4.35
Savings from reduced operating costs b/	.37	1.57	3.42	6.42	10.77
Total Anticipated Savings	$ .78	$2.68	$5.26	$9.46	$15.12
Additional savings if bed to population ratio were reduced 2 percent each year c/	$ .83	$1.89	$3.22	$4.88	$ 6.95

a/ Assumes that debt financing accounted for 80 percent of capital expenditures and was amortized as follows: new beds, 25 years @ 8.5 percent interest; other construction, 10 years @ 10 percent interest; equipment, 3 years @ 12 percent interest.

Assumes that hospitals' own assets accounted for 8 percent of capital expenditures that would have been spent in the year the project was completed.

Assumes that outside but not debt financed sources, primarily philanthrophy, accounted for 12 percent of capital expenditures and were not part of the hospital's costs.

b/ Assumes that for each dollar of decrease in total capital expenditures for a particular year, hospital operating costs in subsequent years would be reduced 50 cents. Also assumes that half the capital expenditures in a particular year would result in savings in operating costs that same year.

c/ Assumes increases in occupancy rate with resulting decrease in cost per patient day; also assumes reduction in hospital utilization from more taut supply. Estimates from W. McClure, Reducing Excess Hospital Capacity (Excelsior, Minnesota: InterStudy, October 1976).

population ratio before 1985 and no additional savings would occur before that time. However, if beds were eliminated, and the bed to population ratio were reduced to 4.0 per 1000 in all areas by 1982, additional savings of roughly $6.95 billion would result (see Table 7). 6/

ALTERNATIVES TO THE ADMINISTRATION'S PROPOSAL

The Administration's hospital capital expenditure proposal is a major step toward a highly controlled system that could run many of the risks of regulation, such as inflexibility and the freezing out of new competition. However, such an approach may be the only way to substantially reduce and redirect new capital investment. There are a number of possible incremental changes in the Administration's proposal that might deal with some of the unresolved problems.

Expenditure Limits

If one believes that the proposed limit of $2.5 billion on capital expenditures is arbitrary, a ceiling related to some measure of need could be devised. One method for doing this would be to assume that current commitments reflect need more accurately and therefore to freeze nonbed capital expenditures at their 1977 level with adjustments

6/ The beds already under construction will bring total beds to approximately 1,050,000 in 1980. If there were no elimination of beds but minimal new beds after that, population growth would not begin to lower the bed to population ratio until 1985 or 1986.

To reduce the bed to population ratio to 4.0 per 1000 by 1982, it would be necessary to eliminate roughly 130,000 beds, bringing the total number down to 920,000.

for expected price increases. If this approach were applied in 1978, the ceiling would be $4.6 billion instead of $2.5 billion; construction projects already in the pipeline would bring actual capital expenditures to nearly $8.0 billion, the level anticipated without a limit.

Another method might be to impose a ceiling of $2.5 billion in 1978 but to let the limit grow over time. The full impact of the Administration's capital expenditure limit is expected to be felt in 1981 when, for the first time, there would be almost no new beds under construction. Thus an increase in the 1980 ceiling would let nonbed expenditures rise at a time when replacement and modernization may be most needed.

Neither an inflation nor a time-based method of adjustment would reflect specific needs for additional investment. A third method might be to establish an exception system for proposals in excess of the $2.5 billion ceiling. States could be granted permission to raise their limits only to the extent that they could demonstrate a pressing unmet need to modernize existing capacity. Other justifications for exceptions might include proposed use of federal energy funds to improve insulation, or other improvements that would clearly save money in future years. The exception system would require more information and staff to administer but would control types of spending and could be used to indicate federal priorities.

State review under the conditions of a ceiling could also be facilitated by establishing a multifactor formula for distribution

among states immediately, rather than relying on population alone. While it would be difficult to establish quickly a formula reflecting health care needs, some simple measures of construction cost and need for renovations such as lack of compliance with life safety codes, could be included. The average of several years' hospital capital expenditures in each state might also be considered as one of the factors if it were believed to have some relationship to need.

Excess Capacity and Maldistribution

Problems arising from the use of an occupancy standard could be dealt with by eliminating it, thus allowing the 72 areas that meet the bed to population standard to expand capacity. If fewer new beds are desired, this could be achieved by a more restrictive bed to population ratio without adding a second criterion such as an occupancy standard. For example, the use of a 3.5 beds per 1000 persons ratio, without an occupancy standard, would permit 29 areas to expand capacity. These areas would be distributed slightly more widely across the nation than the 17 areas that could expand under the Administration's proposal.

Certain changes in the Administration's proposal would make decreases in the number of beds more likely and facilitate the reallocation of resources. For example, each area could be required to establish a year by year plan to reach a target bed to population ratio in five years. Population growth rates could be considered and penalties imposed on hospitals and areas whose bed numbers were out of compliance with the plan.

Additionally, a plan for decreasing the number of beds could be implemented more easily if incentives were provided to individual hospitals for eliminating or converting beds. The Administration's proposal would allow a state to increase its capital expenditure limit when beds are eliminated. However, no incentive would be provided a hospital to eliminate beds in the capital expenditures title. In the revenue controls title, a slight incentive to hospitals would be provided by allowing revenue from unneeded facilities that are closed to be included in the base year calculation. This would have the effect of maintaining a higher level of revenue for a smaller number of beds. The Talmadge proposal would provide direct payments for eliminating beds, but only on a limited experimental basis to not more than 50 hospitals.

Nonbed Investments

The problems involved in reviewing proposals for nonbed expenditures suggest the need for additional staffing and technical assistance for state agencies. Additionally, accurate projections of savings or increases in future operating costs attributable to a proposed capital expenditure could be required as a condition for certificate of need or Section 1122 approval. Incentives could also be provided or priority required for modernization as opposed to technology-intensive changes. This would be complemented by the type of targeted exception system suggested above.

Small Capital Expenditures

If controls were not placed on revenues, increased small capital expenditures might be substituted for fewer large ones. Consequently, there might be a need for legislation that would require reporting of smaller expenditures in the aggregate and penalties for amounts that are judged excessive. It would be desirable to avoid a time consuming line item review of the small expenditures.

Hospital-Type Procedures Performed Outside the Hospital

The problem of hospital-type procedures performed outside the hospital is not easily dealt with. Certain procedures may be less expensive to provide in a hospital than in a physician's office because hospitals are capable of operating at higher volume levels. Such procedures might be confined to hospitals by denying reimbursement if they are performed in nonhospital settings. Other procedures that are much more economically performed outside a hospital may simply bear watching for excessive volume. In addition, certificate of need coverage could be extended to large purchases of equipment not under hospitals' control, such as those in doctors' offices, group practices, and laboratories.

CHAPTER III. THE INTERRELATIONSHIPS BETWEEN TITLES I AND II

The Administration's proposal would assure substantial reductions in hospital revenues in 1978 and beyond. Because of the compounding effect of the annual growth ceilings in hospital revenues and the lowering of the ceiling over time, the amount that the nation spends for hospital care could be almost $19 billion lower than currently projected for 1982 if the proposal were enacted. This estimate represents a minimum savings from the proposal. The capital controls and restrictions on the construction of new beds included in Title II could add significantly to these long-run savings under certain conditions. The reduction in capital expenditures should bring more hospitals' costs below the revenue ceiling. To the extent that savings attributable to reduced capital expenditures are not spent elsewhere, costs, and therefore revenues, would be reduced below the level specified in Title I. However, even if the capital restrictions did not add to the total savings generated by the revenue ceiling, the restrictions on new investments would make it easier to maintain the revenue limits over time by lowering operating costs and thus reducing some of the pressure to raise the revenue limit.

The approaches included under Titles I and II of the Administration's proposal for constraining future hospital costs are, therefore, integrally related. This fact should be taken into account in working

out changes in the specifics of the proposals as well as in their administration. In establishing the level of new investments permitted, care must be taken to assure its consistency with future allowable increases in operating revenue. States, which will administer the capital restrictions, should know the current asset to liability ratio of the hospitals that seek permission to make investments, as well as how capital purchases will affect hospital operating costs.

Moreover, the ability of states to eliminate excess capacity and reallocate resources would be much greater if they were allowed to determine the level of revenues received by hospitals. One way to involve states in a federal revenue control program would be to require state approval of exceptions.

There is some danger in accepting only one of the titles of the Administration's proposal. Controls on large capital purchases without a revenue ceiling could result in an increase in the purchase of less expensive capital equipment, thus maintaining growth in hospital costs. Conversely, a ceiling on revenues without capital controls might allow hospitals to cut back on services needed by the community rather than on duplicative capacity that adds to their prestige.

THE AMERICAN ASSOCIATION OF
NEUROLOGICAL SURGEONS
and the
CONGRESS OF NEUROLOGICAL SURGEONS

WASHINGTON COMMITTEE
for NEUROSURGERY
LOUIS A. FINNEY, M.D.
Chairman
CHARLES A. FAGER, M.D.
RUSSEL H. PATTERSON, M.D.
DONALD H. STEWART, M.D.

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June 13, 1977

Senator Edward M. Kennedy
431 Russell Senate Office Building
Washington, D. C. 20510

Dear Senator Kennedy:

Enclosed is a statement on S-1391 submitted on behalf of the American Association of Neurological Surgeons and the Congress of Neurological Surgeons.

With best regards,

Sincerely,

Donald Stewart

Donald H. Stewart, Jr., M. D.

ml

Enclosure

STATEMENT ON S-1391 SUBMITTED TO
U. S. SENATE COMMITTEE ON LABOR & PUBLIC WELFARE

SUBCOMMITTEE ON HEALTH

June, 1977

Washington, D. C.

by

Donald H. Stewart, Jr., M. D.

representing

AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS

and the

CONGRESS OF NEUROLOGICAL SURGEONS

This statement is being made on behalf of the American Association of Neurological Surgeons and the Congress of Neurological Surgeons whose members comprise the approximately 2500 neurosurgeons practicing in the United States today. We represent a very small segment of the physicians in the United States but a group of individuals highly concerned about the costs of health care in the United States and greatly interested in the reforms necessary to correct the problems which we face as a nation in this area. In the bill proposed by the administration considered here today, it is stated that the purpose of the bill is to establish a transitional system of hospital cost containment by providing for incentives and restraints to contain the rate of increase in hospital revenues, and to establish a system of capital allocation designed to encourage communities to avoid the creation of unneeded and duplicative hospital facilities and services.

President Carter, in his statement referring to this bill on April 25, 1977, indicated that "this legislation is not a wage-price control program. It places no restrictions upon the hospital's ability to determine its charges for any particular service. It places no limit on the size of any wage demand or settlement. The program establishes an overall limit on the rate of increase in reimbursement." We realize that the desire of the administration to control hospital costs is predicated on the apparent increases in these costs and the apparent drain on the tax revenues to pay them. We do not believe that it makes sense to cap the payments to hospitals for services that they provide without capping the charges made to hospitals for the services which they buy.

We have previously testified before the President's Council on Wage and Price Stability and have indicated there what others have also indicated, that the hospital is a consumer and subject to the forces of the marketplace with respect to such items as wages, malpractice insurance,

energy costs, and costs of compliance with Federal and State regulatory demands. Included for the record is a copy of that statement.

We feel that it would not be responsible for the government to exempt wages from the formula contained in this bill as this would allow a pass-through of what could be a rather severe inflationary effect of organized labor by way of wage demands. We understand at the present time that approximately 65% of hospital costs are determined by wages.

We feel that the bill is a very complex one for a transitional bill, and are fearful of the bureaucratic build-up that will be necessary to implement the bill. Mr. Kennedy in his floor statement upon introduction of this bill in the United States Senate, indicated that Americans must work more than one full month of every year to pay for their health care, and he indicated that two weeks wages were required for hospital costs alone. Time Magazine recently reported that the average American worked four months in order to pay the taxes required of the Federal, State, and local governments. If the recent experience with respect to the enlargement of the bureaucracy within the Health Care Financing Administration is any indication of the enlargement of the bureaucracy which will be required to implement this transitional bill, then we are fearful of the cost consequences to the citizenry of our country.

President Carter, in his statement to the Congress supporting the Hospital Cost Containment Act of 1977, indicated, "The Federal sector must also hold down the costs of its own hospitals." This bill specifically excludes Federal hospitals from its terms. The proposal in this bill to limit capital expenditures for the nation to $2.5 billion causes some concern when it is realized that at the present time the Veterans Administration is in the process of a capital expenditure program to construct new or replace old hospitals which will cost $1.2 billion. If indeed the Veterans Administration medical costs amount to $4 billion, which represents approximately 10% of the

annual Federal expenditure for health care, it seems difficult to understand why the Federal hospitals would be excluded from this proposal if the true purpose of the bill is to contain hospital costs.

We do understand the reason for limiting capital expenditures because of the apparent fact that any dollar of capital expenditure generates a lesser sum of yearly maintenance costs which have to be absorbed yearly thereafter. With the requirement that any capital expenditure greater than $100,000 be approved by the various State agencies involved, we are concerned that technological improvement necessary to reduce suffering will be delayed and/or not forthcoming.

In Title I of this bill, hospitals that are dissatisfied with a determination of the Secretary of HEW may obtain a hearing before the Provider Reimbursement Review Board. It is of interest that the Secretary of HEW shall appoint five additional members to the Provider Reimbursement Review Board and that these five additional members shall constitute the Board for purposes of reviewing appeals under this title. We wonder if the bill could be strengthened and any suggestion of conflict of interest be eliminated if the Provider Reimbursement Review Board members were appointed by other than the Secretary of HEW.

This bill is addressed to the problem of controlling costs which have increased at a very rapid rate since 1965 and which, in large part, have been promulgated by the actions of the State and Federal governments through which funds have been provided for increased hospital construction and increased expenditures to support the needs of Medicaid recipients and Medicare beneficiaries. We, like you, are greatly concerned about the increased costs associated with these programs and with the increased costs necessitated by the demands of our citizens for health care. Our people have liked and bought the concept that health care is a right. Legislators have provided some of the funds necessary to buy these services and, as a result, the expenditures

have increased. This bill addresses one side of the problem by attempting to limit the supply of goods and services, but does very little to alter the demand for these. We are not certain how the demand can be reduced at the present time and we are not certain that these expenditures do not represent the true desires of our citizens with respect to their wants and desires and needs. In a nation affluent among others, it is difficult to justify elimination of socially desirable programs.

Perhaps what is needed is some innovative and workable method which will reduce the demand while at the same time not increasing the costs appreciably and not eliminating needed services. We suggest that feasible alternate solutions to these problems may be found by careful study of the proposals made by Senator Talmadge in the Medicare-Medicaid Administrative and Reimbursement Reform Act, S-1470.

We appreciate this opportunity to express our concern about some aspects of this bill and stand ready to discuss the matter further with you if you so desire.

WASHINGTON COMMITTEE FOR NEUROSURGERY

Louis A. Finney, M. D.
Charles A. Fager, M. D.
Russel H. Patterson, Jr., M. D.
Donald H. Stewart, Jr., M. D.

PRESENTATION TO PRESIDENTS COUNCIL

ON WAGE AND PRICE STABILITY

By Donald H. Stewart, Jr., M. D. representing the
American Association of Neurological Surgeons
and The Congress of Neurological Surgeons

Chicago, Illinois July 20, 1976

The American Association of Neurological Surgeons and The Congress of Neurological Surgeons are two organizations representing approximately eighty percent of the neurosurgeons in the United States. As a group, we number less than one percent of the physicians in the United States but we, as you, are concerned about the problems associated with the rising health care costs in our country. We have been attempting to become informed about the various factors contributing to this problem and are pleased to participate in the hearings which you are holding here today.

It would seem that the basic issue to be dealt with is one related to the question of how much can we as a people afford to pay for health care. We expended $118 billion this past year for health care, which is a considerable sum. The rate of increase in the costs has been alarming and to put the question in a larger perspective, perhaps it would be of a value to indicate that in this past year we as a nation spent $52 billion for casualty and liability insurance. We spent in excess of $100 billion for education. We spent $150 billion for housing, $141 billion for household operation, $185 billion for food, $124 billion for transportation, $65 billion for recreation, $39 billion for alcohol and tobacco. These figures are from the Department of Commerce, Bureau of Economics Analysis.

The areas of our specific concern are the problem of rising hospital costs and rising physician costs. It is our understanding that physician costs have gone up at approximately the same rate as that of the general inflationary rate, but hospital costs have far exceeded the inflationary rate. It is our understanding that in this past year approximately $27 billion was paid by private insurance carriers for health care and that $50 billion was paid by Federal, State, and local governments for health care, and that $34 billion was paid by individuals for health care.

It would seem, in trying to analyze the factors related to increased hospital costs, that they can be allocated into three general areas. There

are specific government and legal actions which have contributed to increased costs: the increase in the minimum wage, the increase in Social Security payments, required compliance with retirement laws, increased unemployment insurance, increased costs for utilization review programs, required tests for in-patients, and code compliance activities, to mention but a few.

The development of new services in hospitals has very definitely increased the costs of running hospitals. To give an example of some of those new services being introduced, one should recall the rapid expansion of nuclear medicine facilities, computerized axial tomography, neo-natology units, drug and alcohol abuse programs, and full time emergency room physicians.

There have been forces in the marketplace which have been quite difficult to predict and which the hospital cannot easily control which have contributed to the increased costs. The cost of energy alone has rapidly escalated. As you know, there has been a considerable amount of publicity just recently concerning the increased cost of malpractice insurance to hospitals. The costs of supplies bought by hospitals have been of considerable importance in contributing to the costs of the hospital stay. The increased costs related to hospital worker unionization and the cost of borrowing capital because of lack of grants and gifts must be considered.

There are similar factors responsible for increased physician costs. There has been an obvious increase in the overhead of running a physician's office, consisting of increased telephone charges, increased rent, increased salaries to personnel, retirement plan compliance, not to mention the considerable increases which have occurred just recently in malpractice insurance which at the two ends of our country now ranges between $20,000 and $40,000 per year, whereas just a few years ago it was $1,000 to $2,000 per year. The effect of inflation is certainly a factor to be considered here as well as in the hospital cost area. The increased amount of taxes which are paid is of

considerable import. In the year 1975, taxes paid increased more than any other item in the average budget.

In considering the problem of increased costs, it is interesting to note what actions have been taken by Government to decrease the revenues available to pay for the costs. Various Government programs have mandated losses under the reimbursement formulas. There has been evidence of non-participation of Medicare in certain direct costs relating to patient care and there has been reduction in payment rates to hospitals to offset the value of unrestricted gifts to hospitals, which in effect has reduced the effectiveness of benevolence. Now there has been evidence of retroactive denial of payment for services provided by hospitals. The Cost of Living Council actions of the recent past mandated losses for hospitals.

Perhaps the most disturbing feature about medical care costs as related to hospitals is the fact that it is well advertised that the Consumer Price Index for health care relating to hospital costs is rapidly escalating in the two digit range. Discussion with several persons knowledgeable about hospital costs would indicate that the true cost to the hospital is not reflected by the Consumer Price Index figures. The true cost to the hospital for the services it provides is less than the Consumer Price Index would indicate and the reason for this is somewhat complex but can be explained reasonably simply.

The reimbursement to the hospitals for services provided by Blue Cross, Medicare and Medicaid amounts to a sum less than the actual cost and the disparity is increasing constantly. This means that the hospitals, and particularly those that have a large proportion of Medicare and Medicaid and Blue Cross patients, are operating at a deficit in order to care for these patients. They, in turn, to make up for this deficit, charge a higher rate to the private insurance carriers and to those self-pay individuals, hoping to make up for

the deficit occasioned by the lack of payment for services by the third party carriers noted above. This results in an inflated charge (or price) structure to enable the hospital to meet its actual costs and to take up the slack in the third party programs. The Consumer Price Index draws on these published charges to develop its statistics on hospital costs. This produces an artificial and inaccurate result with regard to what is going on in the area of a hospital's true operating costs. Thus the Consumer Price Index is artificially high and reflects in part the above problem. This aberration must be recognized and dealt with if we are to make a proper data base from which to draw proper conclusions concerning health care costs.

As a result, a good part of the costs for providing health care to those persons covered under Blue Cross, Medicare, and Medicaid is being shifted from the purported carrier to the private insurance industry and to self-pay individuals. Because of this, it has become obvious that some of the private insurance carriers are having difficulties meeting the demands placed upon their premium pools and some have already left the Major Medical insurance field and others are reducing the payments which they will allow and putting the burden for payment of these bills back on the provider and/or the consumer. There have been, as a result of this failure on the part of some carriers to pay the actual costs, a consideration on the part of some very large hospitals of giving up their contracts with Blue Cross which will place severe restrictions on the availability of medical care to those covered under these programs at this time. Perhaps the most peculiar feature is that the system as now operating introduces a very real double taxation to the wage earner who with one hand pays taxes to support the cost of Medicare and Medicaid and with the other hand pays increasing premiums for health care either in the form of higher premiums or greater out-of-pocket costs to subsidize the tax supported portions of health care costs.

As pointed out by Professor Martin Feldstein, Professor of Economics at Harvard University, perhaps the major problem to be considered is the availability of insurance itself. As he quite nicely pointed out in his testimony before the Subcommittee on Health of the Committee on Ways and Means on July 24, 1975, the availability of insurance has produced a system which requires and sustains the introduction of more and more costly services. These services have up until this point, been bought by premium dollars with very little out-of-pocket cost to the patient. But as he also pointed out, the product bought by the insurance is considerably different now, not only in cost but in quality, than it was a number of years ago. A number of years ago a quart of milk was a quart of milk, and it remains the same today. However a day in the hospital today is quite different from that of a number of years ago with respect to the sophisticated and complex modalities available.

One of your panel members inquired in the hearings in New York City as to why it costs more in Medicine to do something better - that is to provide a quality product with respect to medical care - when in industry, as productivity increases and the product improves, the cost goes down. There is a difference between the automatic, mass machine-produced, high quality but lower price product of industry and the sophisticated assessment and delivery of health care as a product. The two products are really quite different. We now, through either government insurance programs or private insurance programs, have wonderful care available for the treatment of renal disease, including renal dialysis and renal transplants, in addition to the well-known open-heart surgery. One of the ironies is that the hospital industry is accused of not keeping costs down and has become the bad guy in recent rhetoric. Hospitals for the most part are not-for-profit institutions. They do not set the charges for the products they buy from industry - industry does. The hospital is not making a profit by charging more - it is merely

trying to pay its bills to industry which is making the profit, but industry is not the bad guy - it is the health delivery system.

One other peculiar irony is that if a 500 bed hospital reduces its length of stay by twenty-five percent by introducing efficiency methods, then in essence it is increasing its bed capacity by twenty-five percent, or by 125 beds. At the going cost of about $80,000 per bed in new hospital construction, this amounts to a savings of $10 million in potential capital expenditures. This type of saving is occurring but is not being recognized.

It is true that these products of modern medicine are expensive and it is also true that they benefit a very small proportion of the population. We in Neurosurgery have available now microsurgical techniques which are being applied to more and more conditions, particularly to the treatment of strokes and the revascularization of the brain. The removal of brain tumors is now much more easily accomplished and much more completely accomplished using microsurgical techniques, and the heretofore very high morbidity and mortality have been reduced considerably. The introduction of computerized axial tomography, which is really in its first generation and which is very expensive, has eliminated in many instances prolonged hospitalization for diagnostic purposes and has eliminated in many instances the costly and somewhat dangerous procedures such as angiograms, pneumoencephalograms and in some instances, myelograms. All of these advancements cost money. There is no question that these expensive items in the milieu of the practice of medicine have improved the quality of medicine, but it is also true that they have improved it for a relatively few people.

It is obvious to those of us who practice Neurosurgery that the reduction in morbidity and reduction in hospital stay and more rapid return to work, occasioned by the use of these more sophisticated modalities, has resulted in an enormous savings in dollars for the segment of the population with which we deal. Neurosurgeons deal with many types of head injuries and

the most outstanding example in the last few years of preventive medicine and its cost-saving to the public has been in this area. With the reduction in the speed limit and with the greater awareness of the population about the dangers inherent in driving and drinking, there has been a 25 percent reduction in head injuries and a considerable saving in terms of medical costs to the population as a whole. We are, however, still concerned with the, as yet incomplete, development of a society-wide concept of preventive medicine and are greatly concerned with the fact that there are still approximately 75,000 persons per year who die of carcinoma of the lung, which has been felt in large part to be due to the effects of smoking. We are still concerned with the 28,000 automobile-related deaths which have been in one way or another caused by the consumption of alcohol, and we are concerned about the 11.5 million injuries which occur in our country as a result of accidents each year, which result in nearly half a million permanently disabled individuals with no small attendant medical cost. We feel that these areas, among others in the area of preventive medicine, could well, if emphasized, lead to further cost reduction to our population as a whole and a shift of the dollar presently being spent on health care to other areas such as education and housing, which would improve the esthetic value of the lives of our citizens.

Finally, we would like to indicate our thoughts concerning the proposed budget for fiscal year 1977 in which it was indicated that there would be a 7 percent limit on increase in hospital charges and a 4 percent limit on physician fees. There was no mention of limitation on other areas in the marketplace and if this policy of the Government is allowed to stand, then the Government will have departed further from the concept of paying the cost of what it gets, and the result will be an even higher Consumer Price Index for the cost of health care as it is now figured. The loser will be the tax paying consumer whose health care is funded through the private insurance industry, as this consumer will be charged even more than he is at the present

time to make up for the deficits created by the failure of the Government to pay the true cost of the goods received. This will inevitably lead to a more chaotic situation and, with fewer private insurance carriers in the field, a greater role would have to be played by the Government with the attendant higher taxes to support the administration of such a plan and to support the very institutions required to provide health care for the people of our country.

Another of your Commission inquired of a former speaker at these hearings as to how National Health Insurance would allow cost controls. It is difficult to imagine after reading the Report on Cost and Quality of Health Care by the Committee on Interstate and Foreign Commerce, published in January 1976, that the Government could effectively impose cost controls. In the State of New York, the Governor has indicated that the administrative costs of the Medicaid program are in excess of 50 cents on the dollar after ten years of operation.

We feel, as others do, that there must be built into any system of insurance a certain disincentive to spend the premium dollar, in part to keep us solvent and in part to keep us from becoming neurotic. We would favor the concept of a degree of co-insurance with any type of plan making it necessary for the consumer to pay the first dollar amounts of any costs commensurate with his true ability to pay this cost. There are administrative problems here and some feel that the health care provider should not collect the first dollar but that the carrier should, whether it be the Government or the private insurance carrier. Regardless of how it is done, unless there is an immediate and not distant financial disincentive to utilize the health care system and its expensive gadgets, there will be continued over-utilization of expensive services and escalation of costs.

We must come to grips with the fact that if the people want the very best, and they do, then the very best will have to be paid for. We must also devise a rational and acceptable way of differentiating our true needs from our wants.

AFSCME
American Federation of State, County and Municipal Employees
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May 23, 1977

Honorable Edward M. Kennedy, Chairman
Subcommittee on Health and Scientific
Research
Committee on Human Resources
Washington, D.C. 20510

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Manhattan Beach, Cal.

Earl Stout
Philadelphia, Pa.

Lee A. Tafel
Miami, Fla.

David K. Trask, Jr.
Honolulu, Hawaii

Maynard White
Houston, Texas

Dear Senator Kennedy:

Attached is our statement for the Subcommittee's hearings on the President's Hospital Cost Containment proposal. Although we will not be appearing before your Subcommittee, we are anxious to assist you in the consideration of this critically needed legislation. Please call me if you have any questions.

In general, we support the Administration's hospital cost proposal, subject to the following amendments:

1) A mandatory exemption from controls of non-supervisory employee wages. Any state cost control program operating pursuant to the Act must also exempt non-supervisory employee wages.

2) Large urban public general hospitals must be exempt from cost controls to provide care for the poor and prevent municipal hospital budget crises.

3) Capital expenditure controls in state certificate of need laws should provide special outpatient expansion and modernization subsidies for big-city public hospitals.

4) Disclosure provisions should be expanded to increase consumer and labor monitoring of hospital finances.

5) Imposition of 9% limit on doctors' charge increases for hospital work; public disclosure of doctors fees, and controls on surgery and wasteful hospital practices.

Thank you for your consideration.

Sincerely,

William B. Welsh
Executive Director
for Governmental Affairs

WBW:r
Enclosure

cc: Claiborne Pell
Gaylord Nelson
William D. Hathaway
Harrison Williams
Richard S. Schweiker
Jacob K. Javits
John Chafee

STATEMENT OF WILLIAM B. WELSH

EXECUTIVE DIRECTOR FOR GOVERNMENTAL AFFAIRS

of the

AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES, AFL-CIO

to the

SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH

of the

SENATE COMMITTEE ON HUMAN RESOURCES

May 24, 1977

Mr. Chairmen and Members of the Committee, I am William B. Welsh, Executive Director for Governmental Affairs of the American Federation of State, County and Municipal Employees. Our union represents over 1.5 million public employees, more than 100,000 of whom work in public general hospitals in 33 states.

We support the Administration's effort to enact stringent hospital cost controls -- indeed our union has pioneered in the effort to cut health care costs. Our District Council 37 was the first union in the country to establish a second opinion surgical consultation program to stop harmful and costly unnecessary surgery. Our members throughout the country have been in the forefront of the Health Maintenance Organization (HMO) and pre-paid group practice movement, to keep people out of the hospital and stop wasteful, fee-for-service medical practice. We have also worked closely with other unions and consumer groups to demand

HEW action to cut down the nation's $2 billion annual waste in overbedded hospitals.[1/]

We have several major concerns about H.R. 6575, the Hospital Cost Containment Act of 1977:

1) The lack of effective cost controls on the actual source of runaway hospital costs -- the way doctors practice medicine.
2) The need for a mandatory exemption from controls for non-supervisory hospital workers -- the overworked and underpaid backbone of hospital care.
3) The need for an exemption from controls for large urban public hospitals, which must legally serve all the poor and which are under severe financial constraints.
4) The need for strict controls on hospital capital expenditures, with special funding consideration for aging and ill-equipped public general hospitals.
5) The need for extensive public disclosure of hospital costs to effect community hospital accountability.

07

COST CONTROLS ON DOCTORS' PRACTICE IN HOSPITALS

Health care cost controls are needed now. But it is indeed an irony that the single largest source of runaway hospital costs and waste -- the way American's doctors practice medicine in hospitals -- escapes completely unscathed from the Administration's cost containment bill. It's almost as if the Administration were to propose a pollution control program with extensive clean-up provisions and nothing to control industrial polluters.

Doctors decide who is hospitalized, what happens to them, and how long they stay in the hospital: Poor medical practice in hospitals costs at least $6 billion each year.[2/]

Doctors decide what kind of equipment the hospital needs -- from wasteful CAT* scanners to fancy, unused open heart surgery units: Sales of CAT scanners in 1977 will be nearly $1 billion and there are 10 times more CAT scanners in use than needed.[3/]

Doctors decide whether hospitals need more beds, and they, of course, decide who occupies those beds: 100,000 excess hospital beds cost $2 billion a year.[4/]

Finally, and certainly most important from the doctors' perspective -- they tell their patients, insurance companies, and the U.S. Government, how much to pay them for their work.

So we have an industry about to come under cost controls on its revenues, and yet the very source of the problem remains completely free to carry on as if it were totally unconnected to the industry. Today's doctors can't function without hospitals,

*computerized axial tomography

and hospitals would go out of business without doctors. In fact, Chicago's St. Anne's Hospital candidly estimated recently that the loss of one doctor from its medical staff would cost the hospital at least $1 million a year in lost revenues.[5/]

Unfortunately, the Administration has chosen to control the doctor's rent-free workshop -- the hospital -- rather than the source of the problem: doctors' fees and the way doctors practice medicine.

Congress should therefore amend H.R. 6575 to curb wasteful medical practices and restrict inflationary doctors' fees. We recommend:

(1) a 9% limit on physicians' charge increases for hospital procedures and treatment. Charges must be available for public inspection in each hospital where a physician has active staff privileges;

(2) a mandatory second opinion requirement for all elective surgery performed in U.S. hospitals; and

(3) mandatory pre-admission certification for all elective hospital admissions.

MANDATORY EXEMPTION FOR NON-SUPERVISORY EMPLOYEES' WAGES

Completely on the opposite end of the hospital wage spectrum from the doctors are non-supervisory employees: for example, hospital aides and dishwashers work alongside doctors and yet earn less than the national poverty level ($5,850 per year) for a family of 4 persons.[6/] Hospital workers deliver at least 80% of all patient care -- without them hospitals would come to a halt. In New Orleans, for example, Charity Hospital's basic salary for a nursing aide I

is $400 a month[7] or $4,800 a year -- a full $1,050 below the U.S. poverty level (after taxes, some employees' take-home pay drops so low that some workers must even seek food stamps just to survive[8]). At the same time, New Orleans area doctors average $5,100 per month or $61,200 a year.[9] Similar, though somewhat less appalling results obtain throughout the country (see Table I - 5A).

It is critically important that Congress and the Administration recognize the plight of public general hospital employees. Since the Supreme Court's decision in League of Cities v. Usery, 96 S. Ct. 2465 (1976), state and local government employees have been denied the federal minimum wage and overtime protections of the Fair Labor Standards Act. Consequently, public general hospital workers suffer a double deprivation: they are not only underpaid but they are unprotected against employers who deny them minimum wage and overtime compensation.

Unlike its hands-off treatment of doctors, the Administration's bill controls non-supervisory hospital employees' wages, subject to the discretion of individual hospital administrators. For the first 18 months of cost controls, the bill gives hospital administrators the discretion of requesting an increase in their revenue caps to pay wage increases to non-supervisory hospital employees.

The Administration's bill covers all inpatient hospital revenues under the 9% cap. Hospital administrators can request a larger revenue increase if they want one, but they must first submit to an exceptions process. Consequently, unless an administrator

95-195 O - 77 - pt. 2 - 7

TABLE I

1975 EARNINGS: DOCTORS AND NURSING AIDS

Region	U.S. Department of Labor* Lower Budget (urban family of 4)	Nursing Aids**	Doctors***
New England	$11,104 (Boston)	$7,220 (Boston)	$51,040
Midwestern	$10,835 (New York)	$10,440 (New York)	$52,420
South Atlantic	$9,222 (Atlanta)	$5,660 (Atlanta & Miami-average)	$60,430
Midsouthern	$9,102 (Nashville)	$6,220 (Memphis, Ark., Miss-average)	$71,800
Southwestern	$9,114 (Dallas)	$5,490 (Houston, Dallas, Ft. Worth-average)	$61,130
Great Lakes	$10,380 (Chicago)	$6,970 (Chicago, Detroit-average)	$63,000
Rocky Mountain	$9,765 (Denver)	$6,370 (Denver)	$58,050
Far West	$10,920 (San Francisco)	$8,285 (Los Angeles, San Francisco, Seattle-average)	$56,800

Sources: *Press Release, Bureau of Labor Statistics, U.S. Department of Labor (April 27, 1977).

**Extrapolated from Industry Wage Surveys-Hospitals, Bureau of Labor Statistics, U.S. Department of Labor (January, 1976).

***Medical Economics, October 18, 1976, pp. 148-149.

ask for an exception, hospital workers' wages will be paid from total hospital inpatient revenues limited by the 9% inpatient revenue cap. Non-supervisory wages will therefore have to "compete" with the hospital administrator's budgetary allocations for high-priced (and almost inevitably wasteful) hospital equipment, high administrative costs, energy, and other hospital supply costs.

What will this mean for non-supervisory employee wages? It will almost without exception mean that hospital administrators choose to spend their additional 9% in revenues on non-wage items whose cost is determined by wasteful medical practice, or sellers outside of the hospital: for example, hospital equipment companies, food and energy suppliers. Wage costs for non-supervisory hospital employees, however, are completely controlled by the hospital administrator. Therefore almost all (if not all) of a hospital's 9% additional revenues will go for non-wage expenditures, leaving already hard-pressed hospital workers with little or nothing to even approximate a living wage. Worse, with little or no revenue allocated for non-supervisory employees, hospital administrators may well resort to layoffs to meet payroll expenses.

While, to some, an exemption for non-supervisory employee wages at the hospital administrator's discretion might appear generous, a look at recent non-supervisory employee wage settlements shows that in the most recent period without cost controls hospital administrators have not been generous. In fact, a pay boost over 9% is rare indeed. (see Table II - 6A-B).

TABLE II

WAGE SETTLEMENTS IN MAJOR PUBLIC GENERAL HOSPITALS 1975-1977

Jurisdiction	Effective Year	General Wage Increase
Atlanta, Georgia Grady Hospital	1975	8½¢
Baltimore, Maryland City Hospital	1975 1976 1977	4.5¢ or 15¢/hr. 5.9¢ 3¢
Boston, Massachusetts General	1975 1976	8% 0%
Cincinnati, Ohio University Hospital	1975 1976	8% or 40¢/hr. 0%
Cleveland, Ohio Mt. Sinai Hospital	1974 1975	17¢/hr. 19¢/hr.
Cuyahoga County, Ohio	1975	6% or 25¢/hr. + 8¢/hr.
District of Columbia D.C. General	1975 1976	5% 4.83%
Erie County, Pennsylvania	1975 1976	$250/yr. 3%
Jacksonville, Florida	1976	7.5%
Memphis and Shelby County Tennessee	1975 1976	3.54% 3.67%
Milwaukee County	1975 1976	9% 4%

continued

Jurisdiction	Effective Year	General Wage Increase
New Orleans, Louisiana Charity Hospital	1975 1976	5% 0%
New York City Municipal Hospitals	1975 1976 1977	6% 0% maximum COLA of 6%
Philadelphia, Pennsylvania General Hospital	1975 1976 1977	12.8% 0% 7%
Wayne County Michigan	1975 1976	4.5% or $450/yr. 25¢/hr.

In view of these figures it is easy to see why a mandatory, rather than discretionary exemption, for non-supervisory employee wages is absolutely necessary to a national hospital cost containment program. Any doubts about the merits of a mandatory exemption disappear entirely in view of two striking facts about non-supervisory employee wages.

First, Bureau of Labor Statistics' comparisons of non-supervisory hospital wages with all non-supervisory, non-agricultural workers, and comparisons with earnings in manufacturing, show that hospital employees are substantially underpaid compared to other non-managerial employees. (see Table III-6-C). Moreover, according to the American

TABLE III

AVERAGE WEEKLY EARNINGS -- PRODUCTION OR NON-SUPERVISORY WORKERS

(January, 1977)

Hospitals	$150.28	(includes interns, residents, accountants who are non-managerial employees)
Total Private (including hospitals)	$179.48	
Manufacturing	$212.94	

Source: Employment and Earnings - April, 1977, Bureau of Labor Statistics, U.S. Department of Labor.

Hospital Association, only 18% of the hospital workforce is organized, making hospitals one of the least organized sectors of the American economy.

Second, and decisive in view of the low wages in hospitals, is the Council on Wage and Price Stability's January, 1977 report, The Rapid Rise of Hospital Costs, which concluded:

> During the past decade, the rate of increase of hospital earnings in excess of the general rise in earnings has been responsible for only about one-fourth of the increase of hospital costs in excess of the general rise in consumer prices.[10/][11/]

In brief, what is needed is an equitable exemption for non-supervisory hospital wages. Specifically, this would require the following changes in the Administration's bill:

(1) a mandatory, rather than discretionary exemption from the cost control cap for the wages of non-supervisory hospital employees.

(2) treating the non-supervisory wage exemption no differently than any other aspect of hospital cost controls, therefore deleting paragraph 124(d)'s delegation to HEW to decide whether to continue the exemption after March, 1979.

(3) requiring any state hospital cost control program operating instead of the Federal program, pursuant to Section 117, to mandatorily exempt non-supervisory employee wages from the state's hospital cost controls.

Each of these amendments is designed to treat non-supervisory employee wages uniformly throughout the country. Equity demands a mandatory exemption for non-supervisory employee wages, and equity demands that non-supervisory employee wages receive the same treatment -- a mandatory exemption -- in each state hospital cost control program.

By mandatorily exempting expenditures for non-supervisory wages from computation of a hospital's inpatient revenue cap, Congress and the Administration will have accomplished two important national health care objectives. First, hospital cost controls will apply directly to the truly inflationary and wasteful portion of hospital expenditures (excess equipment, supply costs, and administrative overhead); and second, non-supervisory hospital employee wages will be free (subject of course to anticipated hospital administrators' resistance) to approach a minimal standard of living.

PUBLIC GENERAL HOSPITALS

It is now common knowledge that the nation's approximately 100 big-city public general hospitals are the last resort for medical care for the poor and anyone else without health insurance. It is also common knowledge that private hospitals have long used public general hospitals as a dumping ground for uninsured patients and anyone else suffering from undesirable, and costly diseases (for example, alcoholics and drug addicts)[12/]. Private hospitals

have consistently resisted and flouted federal Hill-Burton requirements that they treat the poor.[13/] In New York City, for example, at least 75% of all drug addicts are treated in the municipal hospitals which comprise only 22% of all city hospital beds.[14/] New York's public hospitals also treat twice as many poor and minority patients as the private hospitals.

A revenue cap is virtually certain to mean more patient dumping by private hospitals. Their response to cost controls will seek to maximize private hospital revenues by keeping out high-cost, uninsured patients. In fact, the Administration's bill anticipates dumping and indirectly seeks to prevent it.[15/] But the bill's anti-dumping provisions are too weak, because they fail to permit citizen litigation that could force the private hospital to provide its share of free care at the same time the care is needed. Instead, the Administration's bill provides for extended hearings, appeals, and final decisions by the HEW Secretary.

Worse, however, is the fact that the bill subjects public general hospitals to the same revenue cap strictures as private hospitals. Big-city, public general hospitals are already subject to stringent municipal and county government budgetary controls. Moreover, public hospitals are legally required to treat every patient seeking care. Private hospitals are not, of course, under the same budgetary or legal requirements.

It is absolutely critical that Congress and the Administration recognize the consequences of placing large urban public hospitals under the 9% revenue cap. Costs will rise because poorly insured

and uninsured patients, dumped from private hospitals, will require public hospital treatment. To meet these costs, public hospitals will have to raise additional revenues.

While the bill does provide an exceptions process for all hospitals, the process is almost certain to result in costly delays for tightly-budgeted public hospitals. There is simply no reason to endanger these hard-pressed institutions, by subjecting them to costly delays, appeals, and inevitably late revenues. What public hospitals need is a complete exemption from cost controls.

Even under the best circumstances, the exemptions process in the Administration's bill means that large urban public hospitals would only receive a small percentage of the actual cost of providing inpatient services to the poor. The result will exacerbate already-strained public general hospital budgets. Consequently, the big-city public hospital safety-net of hospital care for the poor will be strained and will almost certainly break. And once again, the poor will suffer in the name of cost controls.

CAPITAL EXPENDITURES FOR BIG-CITY PUBLIC HOSPITALS

Overbedded hospitals are costing Americans at least $2 billion annually.[16/] One-hundred thousand empty hospital beds now add at least $75 to each patient's hospital bill. Another $6 billion is wasted annually by America's doctors who unnecessarily hospitalize thousands of Americans each year.

All this waste is directly attributable to doctors, excess hospital equipment and excess beds. H.R. 6575 wisely attacks these problems with a stringent $2.5 billion national limit on new capital expenditures, and restrictions on hospitals seeking additional beds and equipment.

But the bill exempts federal and health maintenance organization (HMO) hospitals from the certificate of need controls. We agree that federal and HMO hospitals deserve an exemption because they are not responsible for overbedding and waste. But we would urge that large urban public hospitals also receive an exemption from the controls. Big-city public hospitals are desperately in need of new equipment and, in some cases new facilities.

Disaccreditations of large urban public hospitals by the Joint Commission on Accreditation of Hospitals have increased dramatically in recent years. Capital shortages for hospital improvements in Philadelphia, for example, lead directly to disaccreditation of the City's only public hospital. Unable to modernize the hospital, Philadelphia's Mayor Rizzo decided to close it entirely, leaving the poor with no hospital facilities. Similar problems plague large public hospitals in New York, Boston, St. Louis, Chicago, New Orleans, Los Angeles and Washington, D.C., to name a few cities.

Any new restrictions on capital or equipment funds for public general hospitals are likely to drive more of them into disaccreditations and closures. The poor rely on public hospitals

as their sole source of health care. Therefore, Congress should act to stop a dangerous deterioration in health care services for the poor by exempting large urban public general hospitals from H.R. 6575's certificate of need limitations.

DISCLOSURE TO FOSTER COST CONTROLS

Public disclosure of hospital costs and conflicts of interest is a major vehicle for cost control. Consumers and hospital workers have long been kept in the dark about hospital costs. Consumers, who pay the insurance premiums that pay hospital bills, and hospital workers, who must toil at poverty-level wages, have no way of knowing where or how American's hospitals spend their whopping $55 billion each year.

A powerful tool for cost control affecting the most flagrant abuses is available in the form of consumer and labor pressure for hospital accountability. Both groups have a vested interest in stopping hospital waste. Yet the Administration merely proposes to require hospitals to disclose their Medicare cost reports (which are already available to the public under the Freedom of Information Act) and limited charge data to be furnished to local Health Systems Agencies (HSAs).

The Medicare Cost Report (SSA Form 2552) is a potentially useful, but baffling mass of data covering some 33 pages. The Report is unquestionably designed to meet the needs of fiscal intermediaries, but it is of limited use to consumers and hospital employees. It fails for example, to list specific administrative,

salary, and major cost center information on such important areas as pathology and radiology. In fact, only a trained hospital accountant could conceivably make good use of a Medicare Cost Report.

HSA semi-annual reports on hospital charges are a useful, but imprecise means to pressure hospitals to keep their charges within reasonable limits. Consumers are unlikely to even know about the HSA lists. What is needed is a disclosure provision that brings hospital financial information directly to the public's attention.

We recommend the following:

A. Each hospital must provide on request at the hospital all cost reports submitted to Medicare, Medicaid and third-party payers during 1975 through the present. In addition, the hospital must disclosure on request at the hospital its IRS Form 990 or an equivalent complete listing of its total receipts, expenses, and disbursements, including its total assets and liabilities for the period 1975 through the present.

B. Each hospital must disclose on request at the hospital the total wages, including all fringes and benefits (for example automobile, housing, etc) paid to its 10 highest paid employees; and in the case of hospitals which pay such salaries, the hospital must disclose the names, salaries and all fringe benefits any employees receiving in excess of $30,000 per year.

C. Detailed conflict of interest statements must be disclosed by the hospital on request at the hospital for all hospital governing board members, administrative staff described in "B" above, and medical staff chairmen.

Conflict of interest statements must list all investments and holdings representing interests in excess of 0.5% in any concern doing business with the hospital.

D. The hospital must disclose on request at the hospital, for the present and 3 most recent years, the total receipts of its pathology and radiology departments, including the gross income received by the physicians in charge of these departments. In the case of anesthesiologists or pathologists and radiologists who practice in the hospital but who bill separately for services, all such physicians must disclose their gross and net incomes for the present and three most recent years.

E. The hospital must disclose on request at the hospital charges for all hospital procedures performed by all physicians with hospital staff privileges.

F. Each health systems agency must collect from each hospital in its health service area at least every 6 months a listing of the total cost for an average stay in the hospital for the 10 most common medical and 10 most common surgical procedures performed by acute care hospitals in the health service area. The health systems agency must promptly compile the listings and each hospital must prominently post the listings at its main entrance area and make the listing available on request to any person.

G. Each hospital must prominently post in its main entrance area the following information:

(1) whether or not the hospital conducts pre-admission certification for all elective admissions.

(2) whether or not the hospital requires a second opinion for all elective surgery.

(3) whether or not the hospital shares services with other neighboring hospitals.

In summary, the American Federation of State, County and Municipal Employees supports the Hospital Cost Containment Act of 1977, subject to the following amendments:

(1) A mandatory exemption from controls of non-supervisory employee wages. Any state cost control program operating pursuant to the Act must also exempt non-supervisory employee wages.

(2) Large urban public general hospitals must be exempt from cost controls to provide care for the poor and prevent municipal hospital budget crises.

(3) Capital expenditure controls in state certificate of need laws should provide special outpatient expansion and modernization subsidies for big-city public hospitals.

(4) Disclosure provisions should be expanded to increase consumer and labor monitoring of hospital finances.

(5) Imposition of 9% limit on doctors' charge increases for hospital work; public disclosure of doctors fees, and controls on surgery and wasteful hospital practices.

Thank you very much.

NOTES

1. Petition of Public Citizen, The American Federation of State, County and Municipal Employees, et al. to Honorable Caspar W. Weinberger, May 7, 1975.

2. Barry Ensminger, The $8 Billion Hospital Bed Overrun, Public Citizen's Health Research Group; Washington, D.C. (1975), pp. 15, 17.

3. Consumer Health Action Network, Vo. I, No. 2, p. 7.

4. The $8 Billion Hospital Bed Overrun, p. 6.

5. CBS Evening News, April 15, 1977.

6. Employment and Training Administration, U.S. Department of Labor Press Release, No. 77-306, April 15, 1977.

7. Proposed Pay Plan Index for Charity Hospital, State of Louisiana, May, 1977.

8. The States-Item, New Orleans, April 20, 1977, p. A-4.

9. Medical Economics, October 18, 1976, p. 149.

10. The rate of increase has been higher because hospitals have only in the last decade been subject to minimum wage and National Labor Relations Act requirements. Hospital non-supervisory wages are clearly well below wages for all other non-supervisory employees.

11. Council on Wage and Price Stability, The Rapid Rise of Hospital Costs, staff report (January, 1976), p. 13.

12. Milton Roemer, M.D. "Patient-Dumping" and other Voluntary Agency Contributions to Public Agency Problems," 2 Medical Care (1973), 0. 30.

13. Marilyn Rose, "The Hill-Burton Act" 6 Clearinghouse Review 309 (1972) and subsequent issues of Clearinghouse Review.

14. Samuel Wolfe, M.D. "Hospitals of the City of New York" (January, 1976) (unpublished), p. 28.

15. H.R. 6575 § 126.

16. Ensminger, Op. cit, p. 6.

95-195 O - 77 - pt. 2 - 8

Statement of the

American Mutual Insurance Alliance

to the

Subcommittee on Health and Scientific Research

of the

Committee on Human Resources

United States Senate

June 16, 1977

The American Mutual Insurance Alliance is the major national association of mutual property and casualty insurers. Alliance member companies provide casualty coverage in all 50 states and the District of Columbia. While casualty coverages usually contain other elements such as wage replacement or disability payments, they also provide reimbursement for medical costs. The casualty insurance industry, therefore, plays an important role in protecting the American consumer against medical loss.

Casualty Insurance Cost Containment Programs

The rapid increases in the cost of health services is of grave concern to the casualty insurance industry. On the one hand, subject to continuing pressures to hold down premiums, while on the other, faced with the increasing costs of services for which it provides reimbursement, the industry has a vital interest in medical care cost containment.

The industry is making every effort to hold down the costs of medical care. In the final analysis, however, casualty insurance cost containment activity is confined to trauma care which represents only about 7 to 8 percent of the demand for health care services. While the industry has seriously attempted to hold down medical losses, it recognizes that these efforts can only be moderately successful because of the pressures created in the much larger balance of the health care system. The industry has long supported voluntary efforts aimed at problem solution. The cost

of care has escalated to the point where it now appears that some sort of a mandatory program has become necessary, however.

Hospital Cost Containment

The Administration has proposed a mandatory solution in the Hospital Cost Containment Act of 1977. Although we would generally support legislation for hospital cost containment, we are not certain the Act presents the proper approach.

In the first place, the bill would limit only the increases in hospital inpatient revenues. Revenues derived from outpatient services such as the emergency room, the laboratories and similar patient services, would not be included under the cap. This feature of the bill is intended to encourage the utilization of less costly outpatient services. At the same time, it provides the hospital administrator with the incentive to increase the prices on outpatient services. Alternately, he may elect to contract out such services to independent physician groups. Thus, while inpatient costs go up at a controlled rate, outpatient costs will probably go up at some indeterminate rate, significantly higher than for inpatient services.

Specific data on the utilization of outpatient services by the casualty system is difficult to obtain. The nature of the system would indicate high usage of outpatient services, especially in the emergency room, however. A lack of controls over cost increases in

outpatient services could have adverse impact on casualty insurance medical losses.

Second, the bill contains no real incentive for the hospital to develop cost-containment programs. Under the proposal, hospitals are virtually guaranteed previous years' revenues plus the permitted increase provided that patient admissions remain at or near the previous years' level. Thus, hospitals with a high per-admission charge will tend to continue those practices which produced the high charge. Such hospitals would, in effect, be rewarded for their inefficiency. Hospitals with lower per-admission rates produced by working cost containment programs would, in essence, be penalized.

Third, while the cost containment program would be comparatively simple for government to establish, we have some concern over the administrative problems which may arise for the insurer. As we understand it, the Medicare intermediary would assume responsibility for determining excess charges per stay for the insurer on the basis of Medicare data. While the bill is not clear, we assume that this determination would occur prior to hospital reimbursement and after the insurer had reviewed hospital charges. Alternately, the Medicare intermediary would need to determine excess charges on all patients, and then forward the bill to the appropriate carrier. In either case, there could be significant delays in payment to the hospital or delays in reimbursement to the patient.

The process of selecting out those charges to be reviewed by the Medicare intermediary and those to be paid immediately, if this is the procedure to be followed, can be difficult for the casualty insurer. Hospital stay for trauma is governed by any number of factors more or less important in each individual case - age of the patient, other existing conditions such as gout or diabetes, for example, which affect recovery. We are concerned that the system established in the cost containment bill will increase our administrative cost.

Fourth, the bill does nothing to relieve the present inequity in hospital care financing under which the cost payors -- government and the Blues -- pay cost while the commercial insurer and the self-pay payments pays hospital charges.

We note that administration's proposal is designed as an interim program, and would agree on a concept that any controls on revenue should be of short range duration. Cost containment programs of this nature tend to create floors rather than ceilings as is their intent. We believe that more effective solutions will be provided through the establishment and implementation of programs already created by the law and in existence in some cases.

Containing Hospital Costs

Much has been written and said as to how hospital costs can be contained. Among the solutions offered is the establishment of hospital cost control commissions. Such commissions, created

by law at the state level, would require hospital facilities within the state to prepare their rates prospectively on the basis of sound accounting budgetary practice. Under the commission structure all purchasers of service will pay the same amount for equivalent services.

We support the establishment of state hospital cost control commissions. We feel that the concept properly implemented will produce economies in hospital operations. We especially favor adherence to the principal of equivalent payment for equivalent services by all purchasers of care. Without this principal, cost saving for one purchaser may well result in cost increase for another.

The commissions are not the sole answer, however, for one of the many reasons for the cost escalation in the hospital sector is excess bed capacity. Unused hospital beds are costly in terms of investment and as well as operating expenses. To absorb these losses, hospital administrators are forced to increase rates on those beds in use. Additionally, the unused bed capacity creates an incentive for longer hospital stays, thus, contributing to overall increase in per case cost.

Another important element in the cost escalation is the duplication of specialized facilities. Such duplication not only increases costs but also can produce shifts in resources from more necessary services. There is little justification for a hospital to add a cardiac surgery unit to its facility, for example, when a hospital a few miles away already has such capabilities

which perhaps may be under-utilized especially when the community may be in more need of a rehabilitation unit.

We note that the administration is cognizant of the problems and has proposed limitations on capital investment by hospitals along with "certificate of need" legislation. We favor these aspects of the administration's programs.

While the hospital cost control commission structure and comprehensive health planning will tend to hold down hospital rates, there is need for another element in the cost control process. A damper on hospital services may be ineffective unless at the same time, some method is found to control the utilization of services. Limiting payments on x-ray or laboratory services, for example, may be counter-productive if there is no limit on the number of x-rays taken, or the repetitiveness of laboratory procedures. Controls over utilization of services have been in existence for some time in the form of "utilization review" committees, certification and recertification of hospital stay, and similar examples. By and large, however, these have not been overly effective and in some cases only applicable to government financed care.

We believe that professional service review organizations offer a solution to the over-utilization problem and its costs impacts. Although these organizations are primarily aimed at assuring the quality of health care services rendered, they do impact on per case cost. Additionally, they could result in the lessening of that portion of the medical care dollar allocated to

defensive medicine. For these reasons, we favor the extension of PSRO's concepts, presently applicable only to patient care financed by government, to all patients irrespective of the payment source.

We would agree with those who urge greater consumer participation in health care financing as one deterrent to the over-utilization of services. It is the patient's decision to enter the health care system which begins the process. We would caution, however, that this needs to be an educated decision. Consumers generally are unsophisticated purchasers of care. We, therefore, support a broad consumer education program involving both government and the private sector.

Uniform Functional Cost Accounting for Hospitals

As we have already stated above, we support the establishment of hospital cost control commissions at the state level as a means to containing hospital cost. An important element in this concept is commission responsibility for the review of hospital rates developed prospectively on the basis of hospital budgets. There is little uniformity among present hospital cost accounting system, however, due to the different preferences of hospital management. One institution, for example, may charge dietary aids used in patient feeding to the operational cost of the kitchen while another will allocate this cost to nursing services. Thus, the review function ordained for the Commission becomes difficult. While a uniform reporting system would solve the

problem to some degree, it would seem to us that the development of a uniform report needs to be based on some common system of cost allocation.

We recognize, however, that there are significant differences between hospitals as to management preferences and the magnitude of hospital operations. In our example cited above, while the 500 bed hospitals would use dietary aids, the 50 bed hospitals might assign this duty to nurses and orderlies. Because of these differences, we would suggest any system established should provide for a certain degree of flexibility.

There are also significant differences between the states as to hospital operations. Since the review function is a responsibility of state hospital cost control commissions, we would urge that the accounting systems developed adhere to requirements established by the commission for the needs of their particular state. A national system which seeks to impose a detailed uniform accounting requirement on all hospitals may produce more information than the commission wants or needs. Thus, cost savings accomplished through the commission approach, could be offset by the cost of installing and operating the national cost accounting system.

Conclusion

The casualty insurance industry plays an important role in reimbursing the costs of medical care services. In recent years, the industry has seen these costs rise at an abnormal rate. The abnormal rises in costs have required the insurance industry to substantially increase premiums.

While we would prefer a voluntary solution to the escalating medical cost problem, we believe that mandatory controls on some sectors of the health care system are necessary. We would agree with the Administration that the containment of hospital costs should have priority. We have some reservations as to the approach presented in the Administration's proposal, however. In our opinion, the establishment of hospital cost control commissions at the state level would be the better route.

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June 15, 1977

The Honorable Edward M. Kennedy
Chairman, Subcommittee on Health
and Scientific Research
Senate Human Resources Committee
4228 Dirksen Senate Office Building
Washington, D. C. 20510

Dear Senator Kennedy:

We ask that the enclosed statement on S. 1391 be made part of the hearing record.

Sincerely,

Connie Holleran

Constance Holleran
Deputy Executive Director
Government Relations Division

(Washington Office)

CH:mm
Enclosure

ANA – An Equal Opportunity Employer

AMERICAN NURSES' ASSOCIATION

Statement On

Cost Containment Act of 1977

As Provided By

S.1391

TO

Subcommittee on Health and Scientific Research

Of The

Senate Human Resources Committee

June 15, 1977

The American Nurses' Association submits this statement for the record in response to the Cost Containment Act of 1977, S 1391. ANA is the national professional association of registered nurses, representing nurses from 50 states, the District of Columbia, the Virgin Islands and Guam.

The ANA shares the concern of the government, citizens and other health providers over the apparent problems created for all of us by rising costs in hospitals, as well as the increasing costs in other parts of the delivery system such as nursing homes. We support all appropriate efforts to restrain these rising costs and offer nursing's assistance in solving the problems. S 1391 is a dramatic effort on the part of the administration to gain reasonable discussion for cost-containment and to seek cooperation and commitment for action to solve the cost dilemma. We support the purposes of this legislation as stated in its preamble.

Everyone in this country is affected by increasing costs of hospital and health services. For those who need to use the services there is an increasing expectation for accuracy of diagnosis, timely treatment and humane care--indeed the miracles of relief from pain, fear and anxiety.

For those who work in hospitals and health care services there is the expectation that the tools, equipment and environment for the delivery of care shall be safe, effective, available, time efficient, clean, and

supportive to the care delivered. Further, these workers both professional and non-professional expect appropriate compensation, job security and recognition for their services, their skills and the contributions they make to the care of the ill and their families.

It is not surprising that the costs of care in hospitals have increased. These costs can and must be viewed as an investment which has been of benefit to thousands and is socially desirable for millions who benefit from the treatment and the cure of people who require hospitalization in order to return to their families and the work force of this nation.

For too many years the tools and equipment were inadequate for the jobs to be done. For too many years the workers, both professional and nonprofessional were inadequate in number, lacking in appropriate skills for the growing complexity of the illness and treatment modalities and grossly underpaid. For too many years hospital trustees adopted policies for expansion of facilities and services on the "keeping up with the Joneses theory" with little accountability for the inflationary aspects of these policy directions. Many institutions were poorly managed and they neither sought nor received public support. When public support did become a major factor, beginning in the early 50's, it was not predicated on any real reform of the inflationary policies already built into the system, but, on the contrary, reinforced and accelerated them.

Responsible attention to correcting these rapidly rising expenditures is required, and the task involves more than simplistic solutions. In spite of a variety of efforts to examine the causes of increasing costs and in

spite of some general agreement that there are a variety of factors included in the list of causes, there is no general agreement about the relative importance of the factors. Is it not useful to believe that this disagreement is valid and that institutions do indeed vary and that specific factors may predominate as causes in large institutions, but not affect the small? Or is size the real determinant? We have in this country attempted to classify hospitals in a variety of ways, but perhaps these classifications are not the most useful. Perhaps large teaching institutions are not alike. Perhaps all hospitals in the 100 to 299 bed categories, often used for a variety of averages and comparisons, are indeed quite different. To assume that cost containment formulas can be effective and equitable and not interfere with the quality of care when applied to the universe of institutions as if they are alike, is highly questionable.

It is our belief that the provisions in S 1391 to control revenues to hospitals by all payors without appropriate reform of the structure of the system of health care delivery and reimbutsement is unworkable, rigid and not an appropriate effort without major revision. As a "transition" proposal it contains no expiration date. Other flaws are numerous. We will address these as follows:

1. To decrease the rate of inflation for health expenditures by attacking only one segment - hospitals - will not be a long-term solution.

   Failure of the legislation to address the actual expenditures for fuel, food, insurance of all types, and supplies which vary by

region and locality, size and purchasing power, etc., will most likely be inequitable for many institutions. Not including some restraint on physician charges and other institutional providers is inequitable.

2. To decrease the rate of inflation for health expenditures without altering the system of reimbursement will deter effective management innovation and control.

The cost reimbursement system is known to be inefficient and provides little incentive for effective management control. The third party system for reimbursement encourages institutional care and does not promote public awareness or understanding of the real cost of health care. The present reimbursement system of medicare and medicaid which does not include reimbursement for services of primary care nurses who can and are able to keep people out of institutions must be altered.

3. To decrease the rate of expenditures for health through a cap on the revenues of hospitals will affect the care and services to those who are hospitalized.

Even if many hospitals which have been operating as cost effectively as possible could tolerate a 9% cap on revenues for one year without reducing staff or services, one year would probably be all that could be tolerated; then staff, services, and indeed quality of care would be reduced.

Although the legislation provides for an exemption for non-supervisory wages - <u>if</u> requested by the institution and <u>limited</u>

to an 18 month period for review of the exemption by the Secretary - the provision is not clear and is discriminatory by not including the very supervisory persons who are essential to implementing any cost effective reforms in the structure and delivery of care system.

The bill places responsibility for certain monitoring and reporting on the health systems agencies (HSA's.) A vital part of the ability of HSAs to fulfill that role depends on mechanisms such as PSRO, and yet it is well known that this review system is inadequately developed. Utilization review as part of that mechanism is perhaps implemented in the majority of institutions. It addresses only the lengths of stay and necessity of admission and has little or no value in determining the quality or appropriateness of the services rendered. However, even if the whole of PSRO were presently operational and standards developed for assessing the adequacy of services provided, that monitoring system has limited value because it does not include the review of all health components but focuses only on medical/physician services. The PSRO system must be altered to include appropriate attention to <u>all</u> professional services including nursing.

4. To decrease the rate of expenditures for health by a revenue cap for hospitals and require certain monitoring functions to be carried by health planning agencies such as HSAs will fail.

The implementation of P.L. 93/641 is two years behind schedule. HSAs are not functional in many areas. Those which are beginning to take hold of what it is they are about are still waiting for

guidelines from HEW in order to implement their role. Priorities are not operational. Funding is and has been totally inadequate. How then can this mechanism be effective in monitoring a whole new set of problems related to implementation of S 1391?

The ANA is most supportive of the health planning legislation and has urged strong nurse representation on the National Council on Health Planning and Development. This Council has yet to be named in full, and we deplore that situation. Unilateral planning and policy decisions by medicine and hospital managers in this country must not continue.

We suggest that this is the underlying cause of the problems in health delivery and the high rate of inflation in the industry, and if allowed to continue, the problems also will continue.

We suggest that in the most effective and cost efficient hospitals in this country you will find that all health professional departments work as a team in true colleague relationships with the hospital administration and with the medical staff. Unless this same partnership exists at the federal planning level as well as at the local level it will be less than effective.

5. To attempt to decrease the rate of inflation for health expenditures by attacking the acute care inpatient services without providing opportunities to develop and expand alternative approaches to inpatient care can, at best, be of only temporary benefit.

The goal of cost containment in hospitals must be pursued in a manner that is compatible with the needs of people. Determinations about what is "medically necessary" care or more importantly what is "health maintenance necessary care", must not be left to the exclusive prerogative of one professional group. Opportunities for developing different models of ambulatory care, home health care, etc., must be in place if more costly services are to be curtailed.

Insurance benefits must be turned around to encourage these less costly modes of services, and include nurses as providers of these services.

6. To decrease the rate of inflation in expenditures for health through a transitional program of revenue caps when present indexes are indicating that a slow down in the rate of inflation is already occuring seems strange.

The proposed legislation calls for a report by the Secretary of HEW by March 1978 directed toward more permanent reforms. There is general agreement that reforms must take place. There is general agreement that more data and knowledge about the cause of inflation and the effects of alternative approaches is required. Is it not also reasonable that if there is an apparent slowing down of the rate of inflation in the health sector this year that the energies of our government and the health sector should be directed to the more desirable alternatives for a long range plan?

We urge the Secretary to establish and use an advisory committee for that report, composed of the American Nurses' Association, the American Hospital Association, the American Medical Association, consumers, the insurance companies, labor, medical supply industries and other interested groups. With the multitude of problems in the reimbursement structure and the system for delivering both illness care and health care in this nation, this cooperation must be forthcoming.

7. To decrease the rate of inflation in expenditures for health care by a revenue cap which carries a section (113) for an admission load formula, which is inadequately conceived will reduce the quality and quantity of services required for safe care of in-patients.

The formula presumes that hospitals are so inefficient that they can absorb a 5% increase of patients at half the cost of the base number of patients. We suggest that is not possible for any hospital to predict or to manage.

The bill assumes that hospitals have the power to admit or not admit patients. It places no burden of responsibility or accountability on the physician. It provides no sanctions on the physicians to comply with PSRO and utilization review to constrain admissions and lengths of stay and to establish appropriate standards of services required.

CONCLUSION

The American Nurses' Association is dedicated to the provision of high standards of nursing services for patients.

We support the objectives of the administration in its efforts to restrain health care costs.

However, we believe that this transitional program would treat only one piece of the problem, and in a manner which would not be useful in solving the problem of inflation in the industry.

The American Nurses' Association supports uniform reporting mechanisms and public disclosure of hospital costs.

The American Nurses' Association supports restraints on capital expenditures, but does not believe the allocation based on population without the needs of the local, regional and state areas being taken into account is useful.

The American Nurses' Association wishes to participate in designing alternative plans for cost containment and believes this requires the participation of all concerned. What is required is true collaboration by the variety of health professionals working with the public. Nursing offers its cooperation to the Congress and the Administration in developing a coherent national policy for health.

sdw
6-14-77

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June 22, 1977

Dr. Stewart Shapiro
Human Resources Subcommittee
on Health and Scientific Research
310 B Senate Courts Annex
U.S. Senate
Washington, DC 20510

Dear Dr. Shapiro:

I have enclosed the statement of the American Protestant Hospital Association on S.1391, the Administration's hospital cost control legislation, for inclusion in the record as requested.

Dr. Charles D. Phillips, President of APHA, was sorry that he did not have an opportunity to present the statement in person and answer questions from committee members. However, having our views on record is the next best thing.

Thank you for your interest.

If I can be of assistance to you on this matter, please call upon me.

Sincerely yours,

Michael S. Cassedy

Michael S. Cassedy
Director of Government Affairs

Enclosure

MSC/skc

Statement Of The
American Protestant Hospital Association
By Charles D. Phillips (Ed.D.), President

Before The U.S. Senate Human Resources Committee,
Subcommittee On Health And Scientific Research
On S.1391/H.R.6575, The Hospital Cost
Containment Act of 1977

Mr. Chairman, I am Charles D. Phillips, President of the American Protestant Hospital Association. Accompanying me today is Michael Cassedy, Director of our Government Affairs Department. The Association represents some 300 hospitals, homes for the aging, and other health care agencies throughout the country, as well as some 2,000 personal members who are engaged in the delivery of health care services. The Association membership is dedicated to providing quality health care to patients within a Christian reference and to ensuring the strength and viability of our voluntary, pluralistic health care delivery system.

Introduction

I thank you, Mr. Chairman, for the opportunity to comment on the President's hospital cost control proposal, S. 1391/H.R. 6575, and the adverse effects it would have on the delivery of health care services. The Hospital Cost Containment Act of 1977 establishes four major purposes: 1) to contain the rate of increase in hospital inpatient revenues; 2) to establish a system of capital allocation designed to encourage communities to avoid the creation of unneeded and duplicative hospital facilities and services; 3) to provide for the publication and disclosure of information useful to the public in making decisions about health care; and 4) to provide for the development of permanent reforms in hospital reimbursement designed to provide incentives for the efficient and effective use of hospital resources. Control mechanisms exist now, we feel, that could effect these desired results without sacrificing the advances hospitals have made in patient care if only they would be strengthened and expanded.

The problem the Act addresses, rising hospital costs, is universally recognized and acknowledged, but the proposed solution -- cost control for only the hospital industry -- would be inequitable, impossible to administer, and unwise for the reasons we will discuss.

The Problem

Hospital costs are rising at a higher rate than the consumer price index (CPI). The CPI reflects the average prices consumers must pay for typical goods and services. Included in this index will be some items which have risen in cost less than the average rate of inflation and some that have risen higher. Hospital charges, considered as one component, are in the latter category. However, goods and services that a hospital must buy disproptionately fall into the higher inflationary category. Some obvious examples are: malpractice premiums, fuel, plastics, and food. Food prices are expected to increase due to this past harsh winter. The costs of fuel, in particular petroleum, and plastic products (oil derivative) are likely to go much higher, but considering the uncertain Middle Eastern oil source, who knows to what extent? Malpractice premium increases will continue to have a double inflationary impact in that the large costs required to meet ever-larger malpractice claims result in the doctors practicing more defensive and costly medicine by performing more clinical tests than are actually warranted. Some of the new technology used in performing such tests are costly to maintain and operate in addition to their high purchase price.

Innovations in medical technology and their proliferation are escalating the cost of medical care. Lawrence Meyer, Washington Post staff writer, pin-pointed this problem in his recent newspaper article (5-8-77), "The Business of Medicine: New Machines Send Costs Soaring." Meyer reports: "According to Roemer's Law -- named after Milton I. Roemer, a physician and professor of health service administration at UCLA's school of public health -- technology and facilities, once installed, tend to be used. Supply creates demand." A good example of this is the CAT scanner (computed axial tomography) which sells for between $325,000 and $700,000. Tests by these machines are expensive, too, as are the maintenance costs. Although the CAT scanner has made the diagnosis of disease more certain, the necessity of every hospital's having one is doubtful.

It must be remembered, however, that a hospital is operated to facilitate a doctor's caring for his patients. Therefore, doctors expect hospitals to get the newest and most sophisticated equipment with which to treat those in their charge. Hospital administrators feel that if they do not have the latest resources, doctors will take their patients elsewhere. This attitude, of course, results in duplicative service which otherwise might be shared among hospitals. On the other hand, the loss of one doctor can mean much lost revenue to a hospital. In the Chicago area that amount has been cited as roughly one million dollars per year for a city hospital.

If supply creates demand in the health care field, then the reverse is also true -- demand creates supply. Medicare, Medicaid, and the Maternal

and Child Health programs, created by the federal government, have greatly increased demand for hospital services. No one would suggest that services to these previously under-served people should be cut back, but they have been another major factor in driving up the cost of hospital care.

Another cost escalator has been the plethora of government regulations that have accompanied these health care programs. Minimum wage, OSHA, ERISA, Life Safety Codes -- all of these constantly changing requirements are costing hospitals more in order to comply. Some regulation, of course, is necessary, even desired, but costly and duplicative reporting requirements should be recognized for what they are -- cost escalators.

Even without federal health programs the American population is getting larger and older. Hospitals, therefore, are being called upon to provide ever more and different services. Add to this the significance of the lack of common health sense exhibited by Americans who are either overweight or who smoke, and it will come as no surprise that our health expenditures continue to go up. The attitude toward illness today seems to be: "It won't happen to me." Yet, when it does, the individual expects the best services and equipment to be ready for his less than five minutes away at a hospital, and despite Karen Quinlan cases, he also expects his life to be preserved at all costs.

Hospitals have largely met these demands and more. However, it is the "more" that is the crux of this issue today. We could go on with reasons why hospital costs have risen as much as they have, but the Committee will hear other testimony on this, so we will address possible solutions to the problem.

Suggested Solutions

In discussing possible solutions to the problem of excess hospital beds, the costs involved in maintaining them, and the desirability of stopping the unnecessary expansion of such services, I contrast the Administration's inadequate suggestions with those that might have more equitable and longer-lasting results.

The Administration's proposal is based upon an unsound concept: limiting hospital revenues to an arbitrary nine percent limit without consideration for the variety in hospital size and services. This cap would apply equally to the efficiently-run facility as to the inefficient. In addition, the bill ignores the reasons for hospital cost increases. There is no incentive to hold down costs so we may find the "cap" becoming a floor.

The hospital industry plays such an integral role in our health care delivery system that the American Protestant Hospital Association strongly urges you, rather than risk chaos and ruin with the Administration's hastily devised and ill-considered proposal, to give more attention to some readily available and existing mechanisms for controlling capital expenditures, service utilization, and the cost of hospital operations.

Excess capital expenditures are, and can be to a greater extent, controlled by Health Systems Agencies created by the Health Planning Act (PL 93-641). HSA's need to be strengthened and improved. Through their administration of the Certificate of Need Program and Section 1122, capital expenditures control, HSA's could more easily and appropriately restrict the growth of excess hospital beds and services in the particular areas that they cover.

Mechanisms also exist for utilization control. The work done by Professional Standards Review Organizations (PSRO's) and hospital-based Utilization Review (UR) committees could be expanded to cover all patients with respect to the medical necessity, quality, and appropriateness of health care provided them. In addition, the Patient Care Evaluation (PCE), performed by the Joint Commission on Accreditation of Hospitals (JCAH), makes similar evaluations. Any or all of these methods of utilization control would work in controlling excess utilization.

Operational control of hospitals, as well as capital expenditure and utilization controls, has been given careful study by Sen. Herman Talmadge and the Senate Finance Committee. After more than a year of research, writing, and revision, Sen. Talmadge on May 5 again introduced his Medicare-Medicaid Administrative and Reimbursement Reform Act (S.1470). In this proposal, operating costs would be determined for categories of hospitals, adjusted to account for area wage differences but excluding cost elements such as costs of capital, costs of education and training programs, and malpractice insurance. The Administration's proposal largely ignores these factors. In addition, the Talmadge bill contains financial incentives for efficient hospital management as well as incentives for phasing out unnecessary beds. Hospitals could work with such a reasoned and equitable approach in contrast to the Administration's proposal.

These are alternatives that the American Protestant Hospital Association would suggest instead of the Administration's plan which would be costly to

administer, would require a huge bureaucracy, but more significantly, would create chaos in the administration of the hospital. The basic formula for determining the revenue limit is retroactive in the first year and does not consider changes in patient mix and services subsequent to the base year of 1976. How can a hospital plan its budget for the coming year based on such a proposal? For those hospitals with fiscal years other than October 1, proper budgeting for the full year will be impossible.

The Administration's proposal will dramatically reduce the quality and scope of services rendered. The nine percent limit will be a disincentive to the continuation of hospital outpatient services, because money from inpatient services will no longer be available to carry the loss. The plan will further discourage hospitals from having more intensive types of care or long-term care services but rather will encourage a hospital to refer such patients to other institutions.

A particular item of concern to APHA members is found in section 115 of the bill dealing with the process of getting an exception to the revenue limits. Will philanthropic reserves be considered in determining the ratio of assets to liabilities under this section? Typically, these funds are bequeathed to our hospitals with usage restricted by stipulations of the will. What are the implications here for charitable contributions? It would seem that the unrestricted funds at least would have to be liquidated, thereby depleting the reserves of a hospital that never could be replaced. Philanthropy for hospitals would dry up, causing a significant impact on other sources of funding. Obviously, a hospital forced to operate on the verge of bankruptcy in order to gain an exception

to the revenue limits would be considered a poor lending risk by any financial institution.

Conclusion

Clearly, we need a national health policy which not only indicates the goals and objectives for our industry, but also specifically provides for a rate of growth constant with the attainment of those goals and objectives. That rate of growth should not be arbitrarily set and indiscriminately applied for all hospitals but should recognize and reflect the differences among facilities.

The Administration's plan would require high administrative costs due to its complexity. Existing controls -- Health Systems Agencies, PSRO's, JCAH, Utilization Review -- are preferred and could be built upon with little additional expense. These methods for controlling excessive capital expenditures and unnecessary medical services provide hospital administrators with incentives to manage efficiently as well as assuring high quality patient care.

The American Protestant Hospital Association fears the confusion and uncertainty that the Administration proposal would create could eliminate much of the progress hospitals have made in patient care by forcing a reduction in existing services. Rather than risk this tragedy, we suggest that Congress at least wait until March, 1978, to see what HEW develops in the way of "permanent reforms in hospital reimbursement designed to provide incentives for the effecient and effective use of hospital resources." Although the bill contains no termination date, HEW says it is an interim program. Hospitals may well face financial ruin under this interim program before more permanent

reforms can be implemented. That is a price I am sure no one wants to pay. We, therefore, must vigorously oppose S. 1391/H.R. 6575 and urge Congress to consider existing mechanisms for containing hospital costs that are more equitable and that insure the viability of our voluntary pluralistic health care delivery system.

Mr. Chairman, this concludes our statement. We will be glad to answer any questions you might have at this time or any that you may care to address to us later on this issue.

American Psychiatric Association

1700 Eighteenth Street, N.W., Washington, D.C. 20009 • Telephone: (202) 797-4900

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June 29, 1977

Hon. Edward M. Kennedy
U.S. Senate
431 Russell Senate Office
Building
Washington, D.C. 20510

Dear Senator Kennedy:

We submit for your consideration, and would appreciate having made part of the Committee's hearing record on cost containment legislation, the enclosed American Psychiatric Association testimony presented to the House Interstate and Foreign Commerce Committee and a joint hearing of the Ways and Means Subcommittee on Health, on May 12, 1977.

Also, the American Psychiatric Association would urge that as the Committee considers cost containment legislation, it provide an exemption for psychiatric hospitals for the reasons stated in the enclosed testimony, and adopt an amendment authorizing a demonstration program, subject to rigorous, ongoing, organized peer review, to determine whether--as we believe it will--that appropriate psychiatric intervention and treatment does reduce medical care costs.

We would be pleased to have the Association's Special Counsel, Jay Cutler, work with your staff in drafting the appropriate provision for your and the Committee's consideration.

Sincerely,

Melvin Sabshin

Melvin Sabshin, M.D.
Medical Director
American Psychiatric Association

cc: Stuart Shapiro, M.D.
Professional Staff Member

Enclosure (1)

MS:sd

TESTIMONY

THE AMERICAN PSYCHIATRIC ASSOCIATION
and
THE NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS
by
ROBERT J. CAMPBELL, M.D.
Speaker-Elect, Assembly of District Branches
American Psychiatric Association
and
Chairman, New York Committee
National Association of Private Psychiatric Hospitals

before the
HOUSE SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
and the
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE
on
H.R. 6575
THE HOSPITAL COST CONTAINMENT ACT

May 12, 1977

Chairman Rostenkowski, Chairman Rogers, and distinguished members of the Subcommittees, my name is Robert J. Campbell, M.D., and I am here to present the views of the American Psychiatric Association which represents 23,000 psychiatrists in the United States, and of the National Association of Private Psychiatric Hospitals which represents 186 free-standing psychiatric facilities.

I am Speaker-Elect of the American Psychiatric Association's Assembly of District Branches, Chairman of the APA's Joint Commission on Government Relations, and Chairman of the New York Committee of the National Association of Private Psychiatric Hospitals. I am also Medical Director of Four Winds Hospital, a private psychiatric hospital in Katonah, New York.

We are in sympathy with the Administration's desire to contain the rapid rise in cost of the health care delivery system but we do

not believe that H.R. 6575 will accomplish the stated objective.

We do not intend to repeat the litany of potential inequities in this pending legislation -- 1) Penalizing efficient lower-cost hospitals, such as the specialty psychiatric hospital; 2) Ignoring the uncontrollable costs of malpractice insurance, energy, fuel, food, and labor, in a labor-intensive field; 3) Stimulating a dangerous schism between hospital administrators and their concern with cost-control and physicians whose concerns are providing quality care to their patients; 4) Discriminating against one sector of the health industry by requiring price controls but yet not controlling wages or supplies.

Rather, we will continue to encourage, as we have in the past, effective measures addressed in the recently introduced Talmadge bill and the Health Planning law.

The provision of both inpatient and outpatient psychiatric care is already severely limited: through the 190-day lifetime limitation in the Medicare inpatient benefit; the $250 outpatient cap on Medicare physician services; and denial of psychiatric treatment to Medicaid recipients, age 22-64 in any facility other than a State mental hospital or a general hospital. These limitations have in effect encouraged the utilization of more expensive and less comprehensive modalities in the delivery of psychiatric services.

The latest year for which data are available, Medicare expenditures for hospital care for mental conditions amounted to $4.40 per person covered--

$3.30 in general hospitals and $1.10 in psychiatric hospitals. This was equal to 2.0% of expenditures for all conditions. There is no indication that more recent data will show these figures have risen other than proportionately to the rise in the elderly population since that time.

Costs in private hospitals are significantly lower than costs in psychiatric units of general hospitals which must bear their portion of the general expense. The average per diem rate runs between $58 to $174 as compared with $250 and $350 for medical/surgical hospitals. The costs of psychiatric hospitals for the most part includes a total therapeutic modality — physician fees, medication, occupational therapy tools, ancillary services, etc. Transfer agreements and contractual arrangements with general hospitals in the area provide for the use on a priority basis for medical/surgical services as they are needed. The treatment of the mentally and emotionally ill, as a rule, does not require nearly as extensive, sophisticated, or expensive testing as does the treatment of physical illness, except in those situations where an organic cause, such as brain tumor may be suspect.

Private psychiatric hospitals, because of their relatively small size, specialization, and insignificance relative to the dramatic rise in medical care costs, should be exempt from this legislation.

Since psychiatry has held a relatively disadvantaged position in the medical community relative to the older, more established services, we believe that the pending Hospital Cost Containment Act, if enacted, would also hurt the delivery of inpatient services in general hospitals. Additional costs of the necessary specialized mental health personnel, essential to the psychiatrists'

treatment of the mentally ill -- psychiatric nurses, psychologists, and social workers -- would become a target for the accountants' cutbacks as a result of this measure, as would the inpatient psychiatric units of general hospitals. General hospitals provide a high level of service to psychiatric patients, especially those in acute stages of mental illness amenable to relatively short-term stays, a median of 12 days. By the same token, Community Mental Health Centers affiliated with hospitals would also become a target for the accountants' cut-backs contemplated by this legislation. If we are to provide the necessary treatment and avoid retrogressing to former inferior methods of treating or institutionalizing the mentally ill, a continuum of all these services must be in place and functioning effectively.

Only 2.5% of those in need of treatment for mental and emotional illness (estimated to be 10% of our population) receives any treatment. If less than 3% of American cancer victims received medical care, it would be considered a national disgrace. Yet, this is hardly the case when we talk about mental and emotional illness, which causes suffering to millions of Americans, and which is life-threatening. For example, suicide has become the third leading cause of death among teenagers.

Our organizations in recent years have made substantial gains in broadening mental health benefits offered by third-party payors. This legislation provides disincentives to third-party payors for continuing any policies that would extend and increase such services, since institutions with growth potential would be penalized for increasing their services.

The field of psychiatry has pioneered to dramatically reduce the inpatient population of state mental hospitals, which has dropped from over 500,000 in 1950 to under 200,000 today. The field has been committed to the principle of treatment within the community whenever possible, and to rapid release if acute mental illness necessitates inpatient treatment.

The American Psychiatric Association and the National Association of Private Psychiatric Hospitals has actively supported the implementation of the National Health Planning and Resources Development Act (P.L. 93-641) as a viable instrument to contain health care delivery costs through rational planning. The APA has also made constant strengthened advances in peer review. We do not believe that cost-controls such as those proposed in this legislation will provide even a short-term solution to these problems, since they have been tried and failed in the past. Also, placing cost caps on institutions will not cut down substantially on those very high cost and/or inefficient institutions. This will merely reinforce maintaining the status quo.

Since this legislation does not strictly apply to these kinds of small and specialized settings, which provide an excellent alternative of relatively inexpensive treatment for the mentally and emotionally ill, and which are significantly lower in cost to other hospitals, we request that private psychiatric hospitals be placed totally in exemption as regards H.R. 6575.

Both of our organizations also believe that the limited inpatient psychiatric service in general hospital units would be severely damaged through this legislation, especially at a time when we are attempting to provide short-

term quality services for the mentally ill.

We regret that we cannot support this legislation but will be pleased to cooperate with the Committees in helping to prepare the appropriate legislative remedy to containing rising health care costs.

AMERICAN PUBLIC HEALTH ASSOCIATION
1015 Eighteenth Street, N.W., Washington, D.C. 20036 • (202) 467-5000

GEORGE PICKETT, M.D., M.P.H., *President*

June 7, 1977

The Honorable Edward M. Kennedy
Chairperson
Subcommittee on Health and Scientific Research
Committee on Human Resources
Washington, D.C. 20510

Dear Senator Kennedy:

The American Public Health Association wishes to submit the enclosed statement for the hearing record of S.1391, Hospital Cost Containment.

Thank you for your attention to our comments.

Very truly yours,

George E. Pickett

George E. Pickett, M.D., M.P.H.
President

Enclosures

S. 1391 - Hospital Cost Containment
comments of the
AMERICAN PUBLIC HEALTH ASSOCIATION
presented to the
Committee on Human Resources
Subcommittee on Health and Scientific Research

June 1977

A major concern of the American Public Health Association (APHA) is that expenditures for health care result in improved health for the nation's population. APHA supports the proposed Hospital Cost Containment legislation detailed in S. 1391, since, in order to make money available for the most effective health measures, the growth of expenditures for relatively less effective hospital services must be reduced.

There are two areas towards which savings resulting from cost containment should be directed. The first is preventive services which can both improve health status and reduce long range expenditures on medical care. The second is to assess the effectiveness of medical interventions by their ability to change individual and community health status. Without prevention, long range expenditure containment is impossible. Without good measures of effective medical care, cost containment will be arbitrary and capricious.

Many people argue that preventive techniques do not work and have not developed to the point where they can improve people's health. This is simply not so. If one realizes that thousands of children in many states lack adequate medical attention, if one sees the devastating effects of tobacco and alcohol, the occupational health hazards in the work place, and how much more needs to be done with such a simple program as immunization, one cannot fail to believe that prevention must be expanded.

There must be a firm financial commitment to those public health and population oriented programs which are not included in the medical care system. (See attachment #1.) We believe that these are the programs that are certain to lose with the advent of national health insurance and that this legislation represents a fine opportunity to make a firm commitment to public health.

Our experience with rising costs has had a disheartening outcome. Although we have expended billions for research, education of personnel, and facilities, the improvement in health status has been minimal.

The simple fact is that in most cases we don't know the effectiveness of medical intervention. It is important to know what our health dollars actually buy and how to spend them most effectively.

The few states and programs that have experimented with population based data on medical care utilization have quickly demonstrated the inconsistency and irrationality of medical care in America. There is a great deal to be learned and much to be saved by reviewing which services are received by which segments of our population and what effect these services have. (See attachment #2.)

We need to reduce spending by preventing health problems, and to spend wisely by supporting only those interventions which improve health status. In doing so, we can simultaneously contain our health care expenditures and improve the health status of our people.

APHA has four recommendations: First, extend the coverage of this legislation to include nursing homes. This would mean that fully 50% of the nation's health expenditures would come under the cost containment act. Second, allow states with adequate population based data systems to distribute a statewide 9% increase in expenditures to those institutions which can demonstrate effective use of health dollars and to those institutions which must expand to meet community needs. Third, with the savings realized under this Act, make a commitment to reinvest a certain percentage for prevention and control of health problems. Fourth, invest another part of the savings in population based data systems designed to indicate the existence of health problems and measure the effectiveness of interventions.

This legislation cannot be justified solely on the basis of the cost savings, for to reduce our defense budget by one or two aircraft carriers would save more. The legislation is a good step in the right direction if it contains a commitment to increase expenditures for prevention and for the creation of population-based data systems that relate dollars and services, not to the needs of institutions, but to the needs of the American people.

SOUNDING BOARD

THE THREAT OF NATIONAL HEALTH INSURANCE TO PREVENTIVE PROGRAMS

NEARLY 60 years ago, the Medical and Chirurgical Faculty of Maryland was issued a warning strikingly relevant today:

> With the appropriations for health insurance running into millions of dollars annually it goes without saying that legislative bodies will not materially increase the appropriations for their health departments. Owing to this fact, there is a decided probability of sickness insurance acts endangering the very existence of State health departments by absorbing all of the funds available for health work. Our statesmen and lawmakers must, therefore, be careful that proper and ample provisions are made for health machinery in any sickness insurance act.[1]

I hope the United States is closer to National Health Insurance now than it was in 1917, but I share the concern of Drs. Warren and Sydenstricker that, in providing for the cost of personal health services, we do not lose sight of the need to preserve and maintain population-directed and preventive health programs. Immunizations, tuberculosis control, venereal-disease programs, and pediatric prevention programs have benefits that extend beyond individuals to whole populations. Protection must remain in place for populations at risk from hazards such as lead paint, malnutrition, rats, occupational exposures, unsafe drinking water and foodborne illness. Yet it seems to me that the benefits of preventive health measures for target populations may be imperiled by the politics of achieving, at long last, national insurance for personal health services.

The total cost of population-directed and preventive programs in the United States, both in and out of government health departments, is less than five billion dollars annually, or less than 4 per cent of the total cost of health services. National health insurance will not sustain these public-health programs; it will pay only for the personal-health-service components. Why should that concern us? Surely, the public-health programs are well established and will continue. Or will they?

Both the British and Canadian experiences with national health insurance suggest that the United States should take special care to protect public-health programs in an era dominated by personal health services. For example, many of us will believe, as physicians in Britain and Canada did, that since national health insurance pays for doctors' visits and pays for vaccines, adequate immunization levels will be maintained. Not so. In both Britain and Canada, after several years of national health services and provincial sickness insurance schemes, health programs directed at hazards to the population are now being redesigned, revived and rebuilt to recapture the target populations for effective prevention.[2] In short, the notion that personal health services could substitute for public-health programs was wrong.

Anyone who has followed Congressional activity around national health insurance is aware that each proposal has a price tag in "new dollars." These are dollars not found in current government health programs, state or federal). The tags range from $73 billion, for the most expensive Kennedy bill, to $31.6 billion for the Long–Ribicoff program for catastrophic-illness coverage.[3] Each sponsor manipulates the numbers to make the price as low as possible. One way this has been done is to deduct expenditures for population-directed and preventive programs currently financed by the government from the new dollar cost of national health insurance. However, national health insurance will pay for only personal-health-services components of these programs, omitting outreach, monitoring, and environmental-control efforts in the process. In other words, Congress may gut productive public-health activities under the mistaken belief that they would be sustained by national health insurance.

How can we avert this setback? Could not national health insurance and better population-directed, preventive programs emerge together? Of course they could. Minimum standards for public-health programs, directed at identifiable populations, can be specified both by content and outcome. Every state and locality could then be required to meet these standards before the federal government extended insurance coverage for personal health services. Surely, it is only reasonable to ask that people receive these highly cost-effective public-health benefits before tax dollars are spent on personal health services. This process need not delay the arrival of national health insurance, since federal cost sharing with states and localities should encourage quick achievement of the essential minimum standards.

As a first step, we should ask the Congress to fund a project by the Center for Disease Control or by the Institute of Medicine of the National Academy of Sciences to develop such standards. Unlike the ordeal of standard setting by PSRO's, I think this job could be done in a year. Professional agreement should be far easier to achieve in this limited area of medicine than in the expanse of personal health services. Once set, the standards may be incorporated into a special cost-sharing provision of all the national-health-insurance proposals in the next Congress. It would be unique perhaps, but extremely worthwhile, if we could avoid the mistakes of others, and maintain our most effective public-health programs while generating, at last, nationwide financial protection for personal health services.

Vermont State Health Department
Burlington, VT 05401

ANTHONY ROBBINS, M.D.

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Harvard University Center for
Community Health and Medical Care
Report Series R-45-5, April 1976

THE USES OF POPULATION-BASED DATA FOR RATE SETTING

Jennifer Robbins

This is one of a series of working papers produced for a project, Integration of Information for Hospital Rate Setting, undertaken under contract # 600-75-0142, Department of Health, Education and Welfare, Social Security Administration, Office of Research and Statistics, Division of Health Insurance Studies.

PREFACE

Since the early 1970's, an increasing number of state governments and Blue Cross plans have been looking to hospital rate setting as a possible means to moderate the every mounting increases in costs of hospital care that have been driving up taxes and subscriber premiums. Although the concept of hospital rate setting has gained wide acceptance as a cost containment measure, there is little agreement so far on means of implementation that will be equitable both to the hospitals that provide the service and to the public that pays the bills.

This is one of a series of working papers from a project that focuses on ways to improve the nature of information available for decision-making in setting hospital rates. Several of these papers describe in detail the types of information currently being used by rate setting programs; others deal with various technical or organizational obstacles that presently block access to the information that such programs want.

Here, the author looks at the question of information for hospital rate setting from an entirely different perspective. She suggests that if truly significant savings are to be made, rate setters must broaden their sights to obtain certain entirely new types of information. She asks them to complement their customary measures of hospital service efficiency at the micro--cost center--level with comparative analyses at the macro level, to show the nature of variations in per capita hospital expenditures and use of hospitals among populations living in different subareas of their states and regions.

The paper illustrates some of the startling discrepancies that can be revealed by such analyses. For example, a fifteen-fold difference was discovered in tonsillectomy days per capita between populations living in two different areas of Vermont. Such differences reflect different physician customs of patient management, and are reflected in correspondingly startling differences in rates of per capita expenditure for hospitalization.

The author is careful to point out that, when faced with such discrepancies, rate setters are in no way qualified to make normative judgments of what might constitute the most appropriate level of per capita hospital utilization and expenditure. Clearly, physicians and epidemiologists must assume the sole responsibility for reviewing the evidence on patient outcome that is required to construct norms of acceptable professional practice. However, she maintains that if hospital rate setting is to be an instrument for improving the cost effectiveness of the health dollar, and for improving the allocation of new dollars for hospital expansions, rate setters have the responsibility for making population based data analyses that raise the questions that these professionals must be asked to answer. In short, the paper suggests that we cannot deal with reviews of hospital utilization and quality of patient care as processes separable from reviews of the manpower, facilities, equipment and, thus, the dollars spent in delivering that care.

The author is uniquely qualified to discuss the integration of hospital service and utilization data in applications of population based data analyses since she was assistant director of the Cooperative Health Information Center of Vermont, Inc., one of the nation's few operating health statistical centers.

TABLE OF CONTENTS

Preface ii

Introduction 1

I. Why Population Based Data? 4

II. Establishing What Is Appropriate 10

III. Ingredients of a Population Based Data System 13

Demographic Data 13

Vital Statistics 15

Data on Resources 15

Facilities 16

Utilization Data 17

Expenditure Data 18

Outcome Data 20

Measures of the Incidence and Prevalence of Disease . . 21

IV. Use and Management of a Population Based Data System 22

V. Conclusion 25

Footnotes 28

LIST OF TABLES AND EXHIBITS

TABLE 1: Estimated Dollars Expended on Tonsillectomies and Adenoidectomies (T&A's) For Persons Under 26 Years of Age in 13 Hospital Service Areas in Vermont, 1969-71 6

TABLE 2: Profile of Indicators of Performance in Five Largest Maine Hospital Service Areas, Showing Incidence of Hospitalization, Per Capita Expenditures, Per Capita Use and Availability of Beds and the Status of Three Institutional Indicators 8

EXHIBIT I: Summary of the Elements of a Population Based Data System 14

INTRODUCTION

Cost control in the health care industry has been an elusive objective of American policy at federal and state levels for at least a decade. In some states, rate setting has been looked upon with favor as a way to achieve that end. Rate setting focuses on correcting the inefficiencies of health care institutions, whose poor management has been widely blamed for at least part of the extraordinary financial burden communities bear for health care. Rate setters have looked for ways to cut costs in hospitals by examining data generated through routine administrative and accounting efforts of these facilities. Policies have been devised to create incentives for more efficiency, upgrading the the skills and practices of an industry plagued by the low priority it has assigned to administration.

Although there can be no doubt that efficiency was (and is) an issue in health care costs, the results of improving it have not brought about cost reductions of the magnitude desired. Despite the best efforts of rate setters and others, costs continue to rise at a pace and to levels that outstretch predictions and other sectors of the economy with alarming regularity. Why is this so?

Part of the answer may lie in the limits of the rate setter's jurisdiction--in only a few states are all third party payors included, for example. But a more basic explanation can be found in the fact that control over key decisions affecting costs in the health care industry have eluded the rate setting process altogether. They have been left both explicitly and implicitly to physicians. Administrators, third party payors and the public through its legislative and fiscal representatives, have avoided tinkering with what have been broadly classified as "matters of clinical judgment."

Sidestepping clinical judgment has produced results of varied economic and social value. Cutting costs by reducing Medicare and Medicaid

95-195 O - 77 - pt. 2 - 11

benefits produces more dramatic results than reducing inefficiency. But it discriminates against those people who are least able to pay for care. It is, or should be, the least desirable course of action, the last resort.

A more equitable approach to cost control has been initiated in a few states where rate setting has joined forces with planning authorities to regulate the growth of the medical care industry, curbing unnecessary expansion of the system through public policies and criteria for justifiable additions to the resources of the industry. But these and other methods geared to achieving the lowest possible unit cost, the greatest efficiency and the least disruption to the provider's patterns of service delivery have not succeeded in curbing the escalation of hospital costs.

Is there another method that could be more effective? Could rate setting do better by moving into unknown territory and by questioning clinical judgments? Like medical care planning and regulation, rate setting has tacitly assumed that the health delivery system's results--the medical care received--were beneficial or effective. Rate setting has had neither the incentives nor the tools to challenge the tradition that assumes "Doctor knows best". That tradition can no longer be left unchallenged by public agencies.

The evidence is now mounting to show that "clinical judgment" is not a scientific, unified or consistent phenomenon. Congressional and journalistic inquiries[1] have echoed the results of a growing body of research establishing the fact that doctors differ widely as to what constitutes appropriate or effective care. Rate setters need a systematic way to incorporate this evidence in their deliberations and decisions. Without it, they may be unwittingly sustaining and promoting the delivery of inappropriate, unnecessary or even harmful services. In short, they may fail to bring about the most useful and far reaching cost reductions.

Rate setters are charged with regulating the expenditure of a sizeable portion of a community's financial resources, or income. Surely, they must ask whether the costs are being incurred in a way that promotes health. And cost control or reduction can be achieved by producing as few

units of service as are needed to achieve health for a population. Reduction of cost through greater efficiency--a lower cost for each unit of service--is desirable, but it can only marginally affect expenditures. It is not at all clear that health care institutions with the lowest unit cost have the lowest total expenditures, or that those with the highest total expenditures produce the healthiest population.

The question is, how can rate setters use evidence of these problems to reduce costs and improve the quality of care? Rate setters are not qualified to evaluate medical care, nor should they be. But they can and should have the data in hand that would enable them to ask the right questions of those who are so qualified. Such data now exist in a few states, and in the very near future may be ubiquitous. (Health care planners will be required, under the National Health Planning and Resource Development Act, to use these data, and there is some evidence of a willingness to commit the necessary resources at the federal level to make such a requirement feasible.) This paper argues that rate setters can vastly increase their impact on the cost of health care by expanding their data base to include information about the population receiving services, the utilization of those services, and the results of those services.

To begin with, the paper describes the rationale for the population based approach, reviews some of the results this approach has produced so far, and compares the new data to more traditional statistics. The kinds of problems in medical care delivery raised by population based data analyses are discussed, drawing from the experience of three existing population based data systems. The kinds of data such a system requires are outlined, including some comments concerning their availability and reliability. Finally, some of the issues regarding management of a data base will be spelled out, including the necessary institutional or bureaucratic relationships around the data base.

I. WHY POPULATION BASED DATA?

Before delving into the issues exposed by population based utilization data, a brief definition of the term may assist those unfamiliar with the methodology of epidemiologists. In Maine, Rhode Island and Vermont, pre-existing information systems are the cornerstones of new population based data systems. Two sets of information are needed: utilization data and demographic data; population based data systems link these two. Using hospital discharge abstracts, services to each patient are recorded and tabulated so that each one can be assigned to the population of the geographic area from which the patient came. Alternately, an enrollment group, such as all persons enrolled in the Medicare program, can also be the reference population. Later, when the aggregate number of services to patients in the population is divided by the total numbers of people in that population, a utilization rate is generated that can be compared to utilization rates in similar populations. Most simply put, population based data looks at the utilization of health care from the perspective of the people being served rather than from the perspective of the institution delivering service. It asks, for example, the rate at which different communities or regions have received appendectomies, and seeks to learn whether the communities with a high appendectomy rate are getting more, or less, effective and appropriate care than the communities with the lower rates. Generally speaking, the population based data mechanism is most useful as a way to flag exceptions, draw comparisons, or identify trends. It is a tool for asking questions more often than it is a tool for providing answers, but the questions it raises are powerful.

In Vermont, for example, data show that women in one area of the state experienced twice as many hysterectomies as did women in another; the range was between 30 and 60 cases per 10,000 women per year. Cholecystectomy ranged between 18 and 53 cases per year per 10,000 women. Appendectomy varied from 14 to 31 cases per 10,000. Translating these kinds of data into the number of hospital days per 10,000 population shows that appendectomy days vary in Vermont from 74 to 188, hysterectomy days from 284 to 670 days.[2]

Who is better off? Does the area with a low surgical procedure rate have people who are sicker or suffer more? Are the people in the high rate areas losing organs unnecessarily? Rate setters are in no way qualified to answer such questions on a case by case basis, but the data make it imperative that epidemiologists and clinicians do seek answers. Certainly if the high rates are directly associated with excess morbidity or mortality, the reasons for such findings should be throughly researched. Licensing, planning and reimbursing bodies can influence the growth and distribution of facilities to make suitable corrections. The human and financial stakes are high enough so that the data must be available to pose these and other questions.

To look at the issue from another vantage point, the tonsillectomy rate may be examined in terms of the number of hospital days per population. Such rates are a function of cumulative physician decisions, first to admit such patients, and then to decide how long such patients should remain in the hospital. In the three year period 1969-71, the tonsillectomy day rates in different hospital service areas in Vermont ranged between 19 and 289 days per 10,000 persons, age adjusted. In other words, there was a greater than fifteen fold variation in days spent in the hospital for a tonsillectomy. Length of stay, on the other hand, varied just two fold, from 1.2 to 2.4 days. Reductions in length of stay could not produce the same magnitude of savings as reductions in the number of operations performed.

Estimates were made of the cost variations for this single procedure--still the most common cause of hospitalization for children, and the most frequently performed surgery in the United States. As Table 3 shows, the area in Vermont with the lowest tonsillectomy rate experienced an annual per capita cost of sixty-three cents; the highest area was a whopping $5.69 per capita. If every community in the state had received tonsillectomies at the lower rate during the study period the total annual cost would have been $337,050. At the higher rate the cost to Vermont people would have been over three million dollars ($3,044,150).

Table 1.

Estimated Dollars Expended on Tonsillectomies and Adenoidectomies (T&A's) For Persons Under 26 Years of Age in 13 Hospital Service Areas in Vermont, 1969-71

Area	Number of Persons under 26 (1000s)	Number of T & As	Total Dollars Expended (x1000)	Mean Cost Per Case	Dollars Per Capita
Total	535	5315	$ 1038	$ 195	$ 1.94
1	16	218	46	212	2.92
2	26	130	26	198	.98
3	10	141	31	220	3.02
4	22	262	55	210	2.51
5	32	351	73	205	2.28
6	48	429	78	183	1.65
7	16	446	90	203	5.69
8	29	253	49	195	1.72
9	21	306	67	219	3.14
10	68	692	144	208	2.11
11	71	888	181	204	2.55
12	162	1146	189	164	1.16
13	14	53	9	167	.63

SOURCE: Vermont Surgery Study, CHICV, 1974, p. 28 (see footnote 2).

At that higher rate, it is possible that over two and a half million dollars (or 1% of Vermonts' medical industry product) could have been spent unnecessarily for this single procedure alone.*

Obviously, before mandating that all Vermonters receive tonsillectomies at a rate not to exceed the lowest experience, one needs evidence to establish that there is not unattended morbidity in the areas with the lower rates. Rate setters cannot evaluate that morbidity, but they can certainly, on the basis of the potential cost savings alone, use these data to create pressure, incentives, or demands on the system that such evaluations be made. With appropriate linkages to peer review organizations or others charged with overseeing the quality of care delivered, rate setters can exert a significant influence on the cost and value of health services.

Without population based data, the rate setter's leverage on the medical care system is much weaker. Institutional indicators of performance simply do not explain the variations in utilization or cost experienced by differing populations. Using data from Maine, Wennberg has compared population-based and institutional indicators of hospital services. As Table 2 indicates, conventional measures of hospital efficiency, such as average length of stay, percent of occupancy and bed turnover rate suggest only modest differences between Area IV and Area V. But comparisons of population based patient days of care show that utilization in Area IV is nearly double that of Area V, with a per capita expenditure rate nearly 34% higher. Wennberg, in reporting these results,[3] notes that Area IV has a high rate of elective surgical procedures, particularly tonsillectomy and hemorrhoidectomy.

Where does this leave the rate setter? It leaves him with a group of questions about necessary or unnecessary surgery. It leaves him with

---

*The actual annual cost of tonsillectomies in Vermont during the study period was $1,039,900.

Table 2.

PROFILE OF INDICATORS OF PERFORMANCE IN FIVE LARGEST MAINE HOSPITAL SERVICE AREAS, SHOWING INCIDENCE OF HOSPITALIZATION, PER CAPITA EXPENDITURES, PER CAPITA USE AND AVAILABILITY OF BEDS AND THE STATUS OF THREE INSTITUTIONAL INDICATORS

	POPULATION DATA				INSTITUTIONAL INDICATORS		
	Incidence of Hospitalization*	Patient Days* of Care	Available Beds*	Per Capita Expenditures*	Percent of Occupancy+	Average Length Stay*	Bed Turnover Rate+
Area I	145	1,104	4.1	102	73	7.6	33
Area II	153	1,244	5.0	92	73	8.1	31
Area III	157	1,054	4.2	75	65	6.7	34
Area IV	235	1,625	5.7	109	72	7.0	39
Area V	127	831	3.8	72	72	6.9	32

*For 1973 population rate per 1,000 population: incidence rate is age-adjusted.

+For 1971
Bed Turnover Rate is defined as average number of admission per available bed.

Source: Wennberg, et al., "Health Care Delivery in Maine III: Evaluating the Level of Hospital Performance", Journal of the Maine Medical Association, 1975, 66, 11: 304

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some disturbing evidence that may need analysis by epidemiologists and by peer review groups, such as PSRO. But it also leaves him with the potential to cut costs (or at least to refuse to allow them to increase) equitably and substantially.

Wennberg has also compiled evidence to show the paradoxical nature of past regulatory and planning decisions that are based on the traditional indicators such as percent occupancy or length of stay. Using permission to expand as a reward to institutions with lower lengths of stay and higher bed occupancy rates--institutional criteria of need--the regulatory decisions affecting new facilities and price control exceptions under Phase II of the Economic Stabilization Act encouraged increased volume in areas already experiencing high utilization. Per capita hospital costs were high in the area with high utilization, and yet based on institutional indicators alone, the Price Commission awarded that area's hospital a price increase, denying it to the institution whose service area ranked twelfth out of thirteen in annual per capita hospital expenditures.[3]

In sum, population based data offers a valuable tool for examining and possibly controlling costs in the health care industry. By examining utilization from the perspective of the population at risk, rate setters can begin to evaluate the productivity of the medical care system. The rate setter does not need to challenge individual decisions by individual practitioners, but when examination of the cumulative choices of many reveals the absence of agreement about what is effective, the rate setter can demand an explanation or a correction. As a stimulus for research the rate setter can begin to set target dates beyond which reimbursement policies will no longer reward areas of high utilization of certain index procedures without evidence that such higher utilization brings attendant benefits.

II. ESTABLISHING WHAT IS APPROPRIATE

The task of determining what is appropriate or effective medical care is enormous. It cannot be accomplished quickly or easily, nor can it be done with equal ease for all medical or surgical therapies. Priorities will have to be set in terms of the impact and feasibility of such research. Rate setters convinced of the need to get into the issues surrounding appropriateness will find themselves in troubled waters: the evidence is not nearly as comprehensive or clear cut as one would wish. The major problem, as Rutstein points out, is "the almost insurmountable difficulty of establishing objective criteria for the measurement of increasing gradations of positive health."[4]

A number of studies, including Rutstein's, are in progress to establish such criteria; the need to do so has been widely recognized, and there are indications of renewed commitment from the Federal Government to support clinical research that will produce the evidence regulators will need. In the meantime, rate setters can improve their control of costs by beginning to move from policies and procedures that assume that all outcomes are effective to a system that asks for evidence of effectiveness.

In Vermont, for example, the State Insurance Commissioner, when presented with data describing surgical variations in the state, requested that New Hampshire-Vermont Blue Cross/Blue Shield investigate the feasibility of a "second opinion" program. Under this program, payment for selected operations is allowable only after two physicians agreed that the surgery was necessary. In New York City, a similar program had reduced the rate of surgery for one population by 30.4%, for another by 17.6%.[5] The savings amounted to over a half million dollars for the two groups (1356 persons). A Congressional Subcommittee has recommended that the second opinion program be instituted for all Medicare and Medicaid patients, conservatively estimating savings at 3.9 billion dollars--and 11,900 lives.[6]

One factor that researchers agree directly influences the amount and rate of surgery done is the number of surgeons, operating suites, and beds available for patients. Lewis found that surgical rates in Kansas varied according to the supply of facilities and personnel committed to performing surgery.[7] In Vermont, this finding was confirmed and a corollary observation made: "By contrast, a higher supply of physicians who do not perform surgery, particularly internists, tends to be associated with lower surgery rates."[8]

Insurance coverage and the way doctors are paid also play a significant role in the amount of surgery and other medical care provided. People enrolled in prepaid group health insurance plans had half as many operations, and were hospitalized a third as often as people with conventional insurance coverage who obtained care from the fee-for-service system.[9]

What all these findings mean to the rate setter is that there are dollars to be saved, expenditures to be eliminated and improvements in health to be achieved by development of a way to (1) systematically review the experience of populations at risk or receiving services; and (2) ask for some answers from the medical profession, the hospitals and the third party payors about true need--in terms of the population, not the provider--for the service or benefit under review. The answers are not all going to be available, but once there are incentives and pressures to produce them, the work to find answers will undoubtedly accelerate.

The mere existence of the data to establish the variations in care can serve as a powerful tool for cost reduction through changes in practice patterns. Feedback of data of this variety to the proper agency or group can sometimes do the trick. In Vermont, tonsillectomy rates in one hospital service area dropped from the state's highest to the state's lowest in one year--as a result of exposure to the data and the subsequent introduction by the hospital of more stringent criteria for performing the operation.

Vayda, reporting on the use of population based surgical data in Canada, cited an example of reduction in rates of hysterectomy in Saskatchewan.[10] Between 1964 and 1971, the rate for the province had climbed 75%. When this evidence was brought to the attention of the provincial College of Physicians and Surgeons, the College was able to develop criteria for the procedure, and ultimately to bring about a reduction for the whole province of 13% in one year. (More strikingly, the College reported a 50% reduction in the city with the highest rate of "unjustified" hysterectomies.) The savings from such a change must be considerable, to say nothing of the reduction in unnecessary discomfort or morbidity. The example further points to the need to make the data available to those charged directly with responsibility for the quality of care, in this case the doctors' professional association. Such linkages are a vital ingredient in the process through which data can be used to improve both the efficiency and the quality of medical care.

Rate setters, health planners and policy makers, and to a lesser extent perhaps the general public, have all been made aware of still another highly significant cost factor in health care: the use of the most expensive facility, the acute care, short stay hospital, is not always appropriate. Less costly alternatives, such as self-care units, homemaker or visiting nurse services, or other forms of ambulatory care need the fiscal stimulus the nation gave to hospitals several decades ago (through the Hill-Burton program, among others) so that they can indeed be used as substitutes to hospitalization. A vigorous effort to shift third party coverage to include non-hospital based services would undoubtedly be resisted by hospital interests, but the savings to be realized for communities at large--to say nothing of the potential reduction in iatrogenic illness--should be sufficient encouragement to move in this direction.

III. INGREDIENTS OF A POPULATION BASED DATA SYSTEM

What then exactly are the data that rate setters should use to establish effective cost regulation? Are they generally available? Are they reliable? How valid are they? Can they be easily understood, unambiguously interpreted, exposed to public scrutiny? The experience in the three states with operating population based health statistics systems is still relatively new, but some of the answers are emerging. In this section, the types of data available (and those still missing) are briefly outlined, followed by a discussion of some of the issues surrounding the management and use of health statistics.

Several types of data are essential for the analyses of the relationship between health and medical care, such as the data which describe: the population of the hospital service area; services received by this population; the resources of the medical care system; their utilization; their expenditures; and the outcomes or results of care. See Exhibit I.

Demographic Data

These are the essential denominators for a population based data system. In addition to the basic information about the size and location of the population (its organization into census tracts, towns, cities, counties, etc.), this group of data includes descriptions of the age, sex, and socio-economic status (as measured by education, or, where possible, income). Rhode Island has the advantage of being totally census tracted—enabling that state's data base (SEARCH) to correlate medical care data with all indicators collected through the U.S. Census. In Maine and Vermont, the town or zip code is used, with more limited census data.

With the decennial census the general population data becomes more difficult to extrapolate by the end of each decade. In some areas, the state census, and/or secondary sources (e.g., school classes)may be used to

Exhibit I.

Summary of the Elements of a Population Based Data System

I. DEMOGRAPHIC DATA

Uses: Denominator for utilization rates
Standardization and comparison
Socio-economic descriptions
Growth trends and projections

Types or
Sources: U.S. Census; State or regional population projections; Vital data (births and deaths); school census.

II. RESOURCE DATA

Uses: Description of providers or producers of services

Types or
Sources: Manpower--Physicians by specialty, location, type of practice; other health manpower

Facilities--Hospitals, chronic care, home health agencies, special care institutions

Hospital Services--Scope of special services

III. UTILIZATION DATA

Uses: Description of product or output of system

Types or
Sources:

Hospital Services	Discharge Abstracts
Ambulatory Services	Claim Forms
Nursing Home Services	Billing Systems
Home Health Services	

IV. EXPENDITURE DATA

Uses: Estimation of cost by service and population

Types or
Sources: Hospital budgets; insurance reimbursement rates and amounts; sources of funds (public and private)

V. OUTCOME OR HEALTH STATUS DATA

Uses: Evaluation of Effects of Care

Types or
Sources: Mortality rates by age, sex, cause of death
Morbidity rates--days lost from work, incidence and prevalence of reportable diseases

supplement census year counts.

More general data, such as the urban-rural mix of the population, and its mobility, are also helpful. Major subdivisions of the population by race, religion or ethnic group may be relevant as well.

Vital Statistics

The records of births and deaths are an essential part of Maine, Vermont and Rhode Island's data systems. Birth and death rates contribute to the growth rate of communities, suggesting especially changes in the age structure of the population under review. In addition, death rates can be used to develop case fatality rates for specific diseases, surgical procedures, and/or segments of the population. However, the reliability of the "cause of death" entry has been variable, and can only be used as an estimate of problems. Detailed reviews of case records may be necessary to determine whether or not these entries are consistent or reliable.

Data on Resources

Traditional measures of the resources of the medical care system--beds, physicians, and the like--are basic to any health statistics operation, but they are far more useful when described in great detail by specialty, and then linked to utilization. Physician counts, for example, are especially poor predictors of use unless they are available by specialty, and by type of practice. In Maine, Rhode Island and Vermont, data are available from published sources and state licensure authorities to identify and describe licensed personnel practicing in each state--and this kind of data is relatively ubiquitous. For the rate setter, such data can shed critical light on the changing patterns of medical care in a community. Surgeons practice surgery, pediatricians see children, gynecologists operate on women, general practioners hospitalize their patients less frequently than internists, and so on. Obvious statements, but often overlooked

when evaluating the "need" for a new surgical suite, and increase in use of coronary care units, and the like.

In Vermont, linkages between data on physician specialty and utilization patterns revealed for example, that 10 doctors accounted for more than half of all the tonsillectomies in the state.[11]

In short, "need" is a function of the provider's resources and choices as well as a reflection of the presence or absence of disease or discomfort in the population.

Facilities

Hospital and other health facility resources are somewhat easier to describe. They can be classified by function, and detailed descriptions of their resources are generally available. What are not generally available, but critical to the rate setter trying to understand how a facility operates in the total health care system, are data linking the facility to the population it serves. Hospital service areas can be obtained from patient discharge abstracts or from special patient origin studies, described below. It is these population based facility data that make the Maine, Rhode Island and Vermont data systems unique and powerful.

Resource data on facilities should, of course, include not only hospitals, but nursing home, chronic care, homes for the aged, specialized institutions (such as a burn center), and to the maximum feasible extent, ambulatory care facilities such as home health agencies, large group practices, and the like. With the advent of national health insurance, record linkages between each of the facilities in a health care system will be feasible. Until then, special studies will be needed to "track" the flow of patients or dollars from one to the other. Individual record abstracts sometimes indicate the site to which a patient has been discharged--i.e., home, nursing care facility, etc.—but connections between two or more facilities cannot be made accurately without unique patient

identifiers, such as a name or Social Security Number. Before unique identifiers are used a strong case for the utility of such an invasion of privacy would have to be put forward.

Utilization Data

The simple addition of the patient's residence on a hospital discharge abstract form makes the essential connection between the service and the population. In Vermont, abstract data comes from the PAS system of the Commission on Hospital and Professional Activities in Ann Arbor, Michigan, a private system to which all but one of Vermont's general hospitals subscribe. Abstracts from the hospital not on PAS are collected manually by staff from the Vermont health statistics center, the Cooperative Health Information Center of Vermont (CHIC). Rhode Island's SEARCH obtains data through a Uniform Hospital Discharge Abstract supplemented with PAS data. In Maine, two pre-existing information systems, PAS and the Blue Cross Data System, cover all hospitals in the state; these are merged to form a single file. These data cover virtually all hospitalizations in short-stay general hospitals of residents of these three states. Vermont data are available as far back as 1969; in Maine and Rhode Island, they extend to 1972.

One way to analyze the relationship between the services and the population is to map the market or service areas of every hospital based on the information in the hospital record abstract. Once patient records have been classified by hospital and town of residence the towns are assigned to the hospital used by a plurality of residents. Thus, if sixty percent of hospital admissions for the residents of Waterbury were to Central Vermont Hospital, the town of Waterbury is assigned to the CVH service area. The population of each hospital's service area thus becomes the denominator upon which rates are calculated. (This may sound like a minor bit of methodology, but hospital administrators have quickly caught

95-195 O - 77 - pt. 2 - 12

the significance of the size of their population base, and watch closely to see that they are assigned towns accurately. One way to lower a rate is to raise the denominator!)

Hospital discharge abstracts, like other large, complex record keeping systems, include some data that are consistently reliable, some that are less so. A review of data quality by the Vermont health statistics center, CHIC, revealed that some data items appeared to be more reliably entered, transcribed and tabulated than others. The age and sex of the patient, for example, appears to be highly accurate. Diagnoses, on the other hand, are less reliably recorded than surgical procedures. Each of the various possibilities for error must be evaluated in terms of the use to which the data will be put. For the regulator, concerned with general trends and comparative rates of occurence, a fair degree of error may be permissable. Gittelsohn summarized the situation as follows:[12]

> If one intends to study geographic variations in the incidence of appendectomy or cholecystectomy, a ten percent error rate in the coding of procedure will be insufficient to obscure two or three fold differences in operative procedure rates by community. For peer review purposes, where study is on a case by case basis, the problem of accuracy becomes predominant. Denial of a claim or a judgment of improper treatment based on miscoded data is intolerable.

It should be further noted that use of the data tends to change (and hopefully improve) its preparation, especially when those who use the data had some hand in its preparation. Thus, a hospital administrator or medical record librarian will assign a higher priority to that task in the hospital if the implications of error are of some significance.

Expenditure Data

A number of approaches have been attempted to estimate the flow of dollars in the health care industry, and to calculate population based

expenditure rates. Most commonly, researchers have had to settle for crude numbers through such means as allocating total reported institutional expenditures according to frequency of admission of residents of each community. (An "average cost" for each discharge is multiplied by the number of discharges from a community, and divided by the number of residents to create per capita expenditure rates.) This technique fails to reflect the variability in costs per case, and tends to distort costs from institutions that offer highly specialized services with very high price tags. However, crude estimates of cost differences between communities can be made, as in Table 2 above, and serve to flag gross variations.

Another technique uses disease or procedure specific cost estimates (such as the California Relative Value Index) and allocates costs to communities for a given medical or surgical reason for admission (as in Table 1, above).

Expenditures reported on claims forms have been used to estimate community costs for services. Published figures on reimbursement under the Medicare and Medicaid programs are aggregated only by county, however, and so do not permit analysis by small areas (town or Zip Code) and hospital service areas. Medicare Part B claims have been used to estimate ambulatory costs for the over 65 population, but this too has obvious limitations. Until national health insurance provides universal claims data, inter-area institutional cost comparisons will be difficult. (The Uniform Hospital Discharge Abstract, as it comes to be used more widely, may offer an acceptable substitute for some areas in the pre-NHI period.)

Rate setters can presumably command the necessary resources to obtain whatever cost data are needed. But much work remains to be done to determine how institutional costs should be calculated on a per-case basis. Until the cost-case-population link is made for each discharge, enabling comparisons between populations, cruder techniques will have to suffice.

Population based estimates of costs have been made in Vermont,

Rhode Island and Maine based on utilization data and price schedules, hospital budget figures and the like. Rhode Island has done a special funds flow study; Vermont researchers have analyzed five months of Medicare Part B claims to estimate the ambulatory part of the cost picture. But until on-going, consistent data are available to link the cost of service to its utilization, this will remain an underdeveloped area for all three data systems. Access to Medicare and Medicaid data on a small area basis, which may evolve under the National Health Planning and Resources Development Act, could go a long way to improve this picture.

Likewise, access to data from Medicare and Medicaid should shed significant light on the other major piece of the puzzle now missing: non-hospital care. Rate setters, like planners and regulators of other parts of the health care system, are now forced to examine information on the use of medical care resources in light that is seriously dimmed: no one has data on the whole system on a statewide basis. Special surveys have been done, and the basic outlines of the picture are pretty clear. But without data on utilization of all medical care services comparable in detail, reliability, and accessibility to hospital utilization information, it will be difficult to perform significant cost-benefit comparisons, or to examine alternative sources of care.

Outcome Data

The murkiest data, the most ambiguous data, and the data that are hardest to come by, are those related to outcome. In the absence of policy and programs to evaluate the results of medical services, regulators are forced to use the rather crude tools of mortality data, and, where it exists, morbidity data. Changes in the quality of life of the medical care recipient are the hardest to measure, and yet the medical care system must be able to continue to meet the needs of people for therapies that improve health as well as prevent death or disability. Much research is needed to develop indicators sensitive to changes in quality of life; in the meantime,

special surveys and studies will be the only measure with which to work.

Randomized clinical trials, which are expensive, technically complicated, and lengthy, remain the best source of data on outcome. These experiments compare the results of different therapies applied to matched populations. The number of reliable clinical trials whose results are widely accepted and agreed upon is woefully small. More research is needed to establish the critical relationship between a particular therapy or technique and its results in terms of reduced pain and suffering or mortality. In the meantime the few existing experimental results should be built into the evaluative armamentarium of all rate setting, planning and policy making agencies in health. With such data in hand, the tasks of such agencies will be far simpler and more productive than can be the case today.

Measures of the Incidence and Prevalence of Disease

Measures of the incidence and prevalence of disease exist for certain problems whose threat to the public health have been recognized, and for which reporting systems and/or effective preventive techniques or therapies have been devised. Thus the incidence and prevalence of diptheria or smallpox can be established in any area of the United States, but the rate at which cancer, diabetes or malnutrition occur in a population can only be estimated or determined by special survey. Indicators such as bed days, days lost from work, or school absentee records are suggestive of morbidity in the population at large, but because they are seldom calculated for small areas and are frequently neither disease specific nor age and sex specific their value is at best limited. Mortality figures from vital statistics offices broken down by residents' age, sex, and cause of death, remain the best overall source of information concerning the population's health.

By now it must be apparent that there are some sticky problems associated with the collection, tabulation, analysis and use of

population based health statistics. For the rate setter unfamiliar with these issues, the problems may seem overwhelming. But it should be remembered that the data have begun to be used in Maine, Vermont and Rhode Island in ways that have direct relevance to the work of rate setting authorities. Crude and incomplete as the tool may be, its utility has been established. Unfamiliar as is the process of incorporating these data into regulatory decision making, it can be done. Although the dangers of drawing unwarranted inferences exist, they can be lessened to a very great extent through cooperative arrangements between regulators, planners and clinicians. The important point is this: the data raise questions that must be addressed in the interests of appropriate costs and better health. To be sure, the question of whether a surgical procedure rate is too high or too low cannot be answered simply. It may require a special study, it will require analysis by surgeons, among others, but it must be asked.

The evidence that utilization rates differ widely between communities cannot be ignored. Rather, the reasons for such differences and measurement of their outcomes in terms of costs, reduction in pain, reduction in morbidity or increased function for people should be rigorously examined, so that explicit choices can be made for more or fewer resources.

IV. USE AND MANAGEMENT OF A POPULATION BASED DATA SYSTEM

Data use and data management are closely linked. Where the data base is located affects its use in many ways, including its access and its credibility. The technological problems associated with merging and manipulating very large data files derived from quite different information systems are sufficiently complex to warrant the development of a single staff.

White, discussing various options for location of health statistics operations, points out that "what does not seem to work is to bury

statistical units within a bureaucracy, in close proximity to the operating elements of that organization."[13] White points to several reasons for the need for an independent data unit, including objectivity, or credibility, the need for data uniformity (and the power to arbitrate between conflicting data needs), and the need to avoid redundancy, data ommission, and excessive cost.

Both Rhode Island and Vermont have incorporated their data bases as free-standing organizational entities established specifically to respond to the needs of many parties for objective, reliable data. Rhode Island's SEARCH is governed by a Board composed of representatives of various interested agencies and groups in the state. In Vermont, the Cooperative Health Information Center has a Board whose majority is composed of public representatives, from outside the health industry. Both organizations function as nonpartisan participants in the health care system in their respective states, "operating on the assumption that data which are collected by appropriate scientific methods and analyzed and interpreted with care will serve the interests of the entire community."[14]

In Vermont, the independence of the data base has greatly influenced its credibility with the various parties participating in what must always be an adversary process, the planning and regulation of the health care industry. CHIC's output has been used by the state's Professional Standards Review Organization, the Comprehensive Health Planning Agency, the Health Department, Agency of Human Services, Hospital Association, Medical Society, individual physicians, university based researchers, and others.

The Vermont and Rhode Island arrangements reflect at the state level a similar arrangement at the federal level. The National Center for Health Statistics has served as a statistical resource for health policy and program development and operations for more than a decade. Three years ago, it assumed major responsibility for developing a Federal-State Local Cooperative Health Statistics System (CHSS), and the DHEW's Forward Plan for 1977-81

indicates that support for CHSS will be augmented and extended so that it can provide nationwide the necessary statistical base for all operating health related programs.[15] Both the Rhode Island and Vermont data bases received their initial support from the CHSS, and continue to get part of their financing from that source. However, as the data are used by other federal as well as state and local agencies, financial support for the statistics centers has been broadened to include these agencies.

The National Health Planning and Resources Development Act calls for extensive reliance by its state and regional agencies on a population based data system, and specifically on the Cooperative Health Statistics System. Some day the advent of National Health Insurance will impact directly on state and local level arrangements for data management and control. At this point one can only hope that there will be an effort to protect the credibility and integrity of data programs.

Public health statisticians, epidemiologists and other professionals needed for the operation of large and complex health statistics systems are few and far between. One important reason to set up no more than a single health statistics unit in each state is to be able to attract and get maximum benefit from the scarce manpower resources available.

Where a data base lands in the bureaucracy of health will influence who gains access to the statistics. Because of the newness, complexity and potential of these data, cross-fertilization in use, analyses and interpretation of the statistics should be encouraged. The data are a logical point of contact and cooperation between peer review or quality control groups, planners and rate setters.

Access raises the corollary issue of confidentiality. In the absence of a body of law or experience to govern procedures for release and use of data based on individual patient records, the establishment of a single set of rules in a single agency for the aggregation and use of data seems an appropriate minimum. How far public exposure of the data can go is bound to be hotly debated, as it has been around the PSRO data.

But it is important to remember that population based data files are used as aggregates; profiles are drawn of groups of people, not single individuals. At no time in any of the three existing data centers are individual patient names or numbers part of the processing or tabulation.

The rights of a patient to protection of his or her privacy are clear; the rights of providers to such protection are not so clear. It seems likely that the health care industry is moving toward a time when it will accept the burdens of public accountability, and the discomfort of public scrutiny that goes with it. The penalties for lack of disclosure will be great, both in terms of public trust, and in terms of public funds. Presumably, procedures for data access developed under the National Health Planning and Resources Development Act will recognize at the very least the necessity for free exchange of data between rate setting, peer review and planning agencies. Procedures to protect against unwarranted disclosure and to guarantee redress of grievances are now being developed. Ultimately, the credibility of the health care industry will hinge on full public disclosure of aggregated, reliable data on performance and require that provider data be used by public agencies.

V. CONCLUSION

This paper has examined the potential of a relatively new tool in health care in the United States, population based health statistics systems. It has argued that, with this tool in hand, agencies charged with controlling or regulating the costs of health care can do that job far more effectively. Wide variation in the utilization of services by different populations suggest that reductions in some types of utilization could be achieved without harm and at substantial financial savings to the communities served.

Hospital rate setters cannot by themselves resolve the questions of

which types of utilization rates are too high or too low. However, by examining the data, they can begin to find some of the reasons (such as more surgeons produce more surgery) explaining the variations. They can, most importantly, develop the ammunition to challenge the industry's traditional notion of "need". In the past, rate setters have not been able to refute the "need" for additional hospital resources that hospitals alone define. The measures used to justify those "needs" have been institutional indicators of high volume performance, and these measures were per se limited: they did not describe the population, or even suggest its requirements, nor were differences in volume related to differences in patient outcome, or differences in the health status of populations described. Equipped with population based utilization statistics, rate setters can examine patterns of use over time, compare them to neighboring regions, to state averages, to hospitals of comparable size and complexity, and the like. Eventually they may be able to deal with the issues of productivity in terms of the health status of people rather than the "efficiency" of institutions. They can make cost control a partner to quality control.

How feasible is all this? The answer is that it is highly feasible. In Maine, Vermont and Rhode Island, existing data systems formed the backbone of the data base; other states will be able to use similar resources. By 1981, the Department of Health, Education and Welfare anticipates that all fifty states will have hospital care data comparable to these three New England systems. Vital data and census data are available everywhere. These data sets are enough to start a system; augmented with hospital abstract discharge data, rate-setting cost data, Medicare and Medicaid data, ambulatory and insurance data, special surveys and resource directories the data base can become a true lever for change and a vital aid to understanding the relationship between medical care and health.

There are problems, of course, and some of them have been suggested. This is new territory not only for rate setters, but for statisticians,

public health officials, clinicians and public policy makers. Technological issues, political issues, and bureaucratic issues remain to be resolved. But the early experience is most promising, and there is no particular reason to assume that if these problems can be addressed successfully in three states they cannot be resolved with equal alacrity and success elsewhere.

FOOTNOTES

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12. Notes of Data Quality, Cooperative Health Information Center of Vermont, Inc., Burlington, Vermont, September 1974, 12.

13. White, K.L. and J.L. Murnagham, "Health Care Policy Formation: Analysis, Information and Research", International Journal of Health Services, Winter, 1973, 3:81.

14. SEARCH Reports, January, 1975, 13.

15. Forward Plan for Health, FY 1077-81, U.S. DHEW, PHS, June, 1975, 188-198; see especially p. 198.

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June 22, 1977

The Honorable Edward M. Kennedy
United States Senate
Washington, D.C. 20510

Dear Senator Kennedy:

The American Society for Medical Technology respectfully requests that the enclosed statement on the Hospital Cost Containment Act of 1977 be included in the record of the hearings conducted by the Human Resources Subcommittee on Health.

Sincerely,

Beverly J. Fiorella

Beverly J. Fiorella
President

BJF/lu
Enclosure

STATEMENT

SUBMITTED BY

THE AMERICAN SOCIETY FOR

MEDICAL TECHNOLOGY

IN

CONSIDERATION OF THE

HOSPITAL COST CONTAINMENT

ACT OF 1977

American Society for Medical Technology
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I. INTRODUCTION

The American Society for Medical Technology (ASMT) is pleased to provide the members of the Senate Human Resources Subcommittee on Health with our views on S.1391, the Hospital Cost Containment Act of 1977.

ASMT is a national, professional organization composed of over 29,000 members engaged in the delivery of clinical laboratory services. The Society is composed of 50 constituent state societies, in addition to the District of Columbia, which hold charters granted by the national organization. The country is divided into ten regions with an average of five states per region. An elected House of Delegates forms the governing body of the Society and when not in session, its functions are carried out by an elected Board of Directors.

Our membership is made up of a variety of nonphysician categories of clinical laboratory personnel including clinical laboratory administrators, supervisors, educators, technologists, technicians, assistants, and such specialists as microbiologists, clinical chemists, hematologists, immunohematologists, cytotechnologists, histotechnologists, and nuclear medicine technologists.

Approximately seventy-five percent of our membership hold degrees at or above the baccalaureate level while another ten percent hold associate degrees. The remainder of the membership is composed of individuals who fall in specified categories such as students.

In addition to a membership diverse in specialty and generalist functions within the laboratory field, laboratory settings or places of employment range from private or independent laboratories to physician offices, clinics, blood banks, research institutes, to hospital laboratories -- both governmental and non-governmental. Thousands, in fact the majority, of our active members work in hospital laboratory settings throughout the country.

II. BACKGROUND

ASMT shares the strong concern expressed by both the Administration and Congress regarding the serious problem of rapidly increasing health care costs. In the laboratory field alone during 1975, it is estimated that about $12 billion was spent performing approximately 4 1/2 billion tests or roughly 10 percent out of the total $120 billion spent for health that year. Moreover, it is projected that by 1980 laboratory costs will reach $15 billion annually, even without a national health insurance plan in effect. While general expenditures for health have been increasing at the rate of about 11 percent a year, laboratory services and fees have been expanding at the rate of 15 percent a year.

Our Society recognizes that the critical problem of controlling the sharp rise in health costs, particularly as they relate to hospitals, must receive priority attention before a

national scheme for health care is enacted. In this regard, we believe that the proposed legislation provides an excellent opportunity to engage in a meaningful dialogue within the public and private sectors on what basic reforms are necessary to fundamentally alter our current health care system in prelude to developing a rationally conceived national health insurance program.

The available evidence involving escalating hospital costs suggests a serious national problem requiring careful congressional evaluation in the process of developing an appropriate and long-range cost-containment strategy. For example, over the past decade, hospital charges have constituted the single most inflationary bulge in the Consumer Price Index of goods and services. Moreover, while the cost of living went up 86% between 1960 and 1976, the average cost per patient day skyrocketed 450% from $32 to $175. In fiscal 1976, 40 percent of the $139.3 billion spent nationally on health care was spent on hospitals. With hospital charges jumping around 15% a year and the national price tag for hospital care approaching a staggering $65 billion, it is not surprising that many knowledgeable observers have increasingly sounded the alarm at runaway hospital costs.

ASMT takes the position that health care costs are rising at an unacceptable rate and that strenuous and expeditious efforts must be undertaken to change this long term trend. It

95-195 O - 77 - pt. 2 - 13

is for this reason that the Society endorses the basic intent of the Administration's proposal although we cannot support the specific methodology employed within the legislation for three major reasons. First, we do not believe the approach advanced by the Administration is supportive of necessary structural reforms in the health care system. Secondly, capricious cuts in hospital expenses which are certainly possible under the proposed bill could occur precisely in those areas that would be both detrimental to immediate patient care as well as inimical to the continuation of appropriate and necessary educational programs currently established within many facilities. Finally, the proposal does not provide any positive incentives to bring about voluntary efforts which would contain costs.

III. THE ADMINISTRATION APPROACH

The major objective of the Administration bill is to limit the inpatient revenue increase of all acute care hospitals to approximately nine percent. Under the legislation, new hospitals, extended care facilities, Federal hospitals and HMO's would be excluded from this provision. Additionally, any covered hospital may request an exception from meeting the revenue limit where it expects an extraordinary change in patient load or major changes in capital equipment and services. A hospital's permissible increase in revenues could be adjusted upward to allow for actual wage increases granted to non-supervisory employees.

Moreover, any state which operates its own cost containment program and can meet Federal criteria may apply its own regulatory program to hospitals in lieu of the proposed Federal plan.

Among the other major provisions contained in the legislation is an annual national limit on new capital expenditures and a limit on certification of need under specified circumstances. Finally, the legislation requires the Secretary to submit a report of his recommendations for "permanent reforms in the delivery and financing of health care."

The Society is particularly concerned that the Administration's proposal could result in a restriction in quality hospital care especially for those services traditionally provided by non-physician personnel. Given the pressure on hospital administrators to stay within the nine percent limit, it is probable that arbitrary personnel reductions in absolute numbers and/or realignments utilizing lesser qualified personnel would occur which could well result in a decline in quality care.

Moreover, the "cap" concept is arbitrary by its very nature and tends to penalize efficient institutions while rewarding those which have tended to be inefficient. Take the case of an institution which may make every attempt to be efficient and keep within the nine percent limit but finds that its costs from certain outside suppliers have doubled or more within a calendar year. Such an institution which had no fat within its budget

would have nothing to cut but would still have to pay higher prices imposed from external suppliers. On the other hand, the inefficient institution which had an inflated budget to begin with could reduce unnecessary expenditures to accommodate higher costs for supplies and equipment.

ASMT believes that part of the solution to spiraling hospital costs involves developing positive incentives for hospitals such as promoting the closing and conversion of underutilized facilities. Merely putting a cap on hospital revenues without also applying positive incentives striking at some of the basic structural problems inherent in the current system could well convert the cap into a floor -- an end result which neither the public nor private sector desires. This is particularly important in light of the fact that on any given day, an estimated 25% or about 240,000 of the nation's acute care beds are empty. In this regard, an Institute of Medicine study group last fall concluded that the maximum ratio of short-stay beds to population should be four per 1,000 and recommended that some 90,000 beds would have to be closed in order to achieve that goal by 1981.

While ASMT does agree with several provisions contained in the Administration plan relating to the proposed limitation on capital expenditures and certification of need along with accepting specified state cost containment programs in lieu of

Federal controls, we believe that any Federal program adopted must also deal with basic structural changes in hospital and practitioner reimbursement as well as an acceptable method of containing costs incurred by hospitals from outside suppliers.

IV. ALTERNATIVE SOLUTION

Although there are no easy answers to the serious problem of escalating health care costs, the Society believes that it is preferable to develop basic structural changes in the health care system just as soon as possible rather than relying on the proposed transitional plan proposed by the Administration which may in fact cause more problems than it actually solves.

One proposal which we believe deserves careful consideration is the Medicare-Medicaid Administrative and Reimbursement Reform Act recently introduced in revised form in the 95th Congress. Among the desirable features of this legislation are its various long-range measures relating to both hospital and practitioner reimbursement along with basic long-term care and administrative reforms under Titles XVIII and XIX of the Social Security Act. Of particular importance in this proposed legislation (missing entirely from the Administration plan) is an approach to hospitals in which penalties and incentives would be built in to the reimbursement mechanism and based on group performance.

ASMT would recommend that Congress consider combining the best features of both the proposed Administration and Medicare

Reform proposals. We would like to see the long range approach contained in the Medicare Reform legislation broadened to include all reimbursement mechanisms with its effective date for compliance advanced to 1978. Moreover, we believe some form of capital expenditure and certificate of need limitations should also be incorporated into the legislation.

ASMT additionally recommends that the following important areas receive careful consideration in the development of any long-range strategy to contain health care costs.

1. More effective utilization of non-physician health practitioners.

While the Congress has recently begun to seriously grapple with the sensitive issue of expanding the role of non-physician health personnel in order to relieve physicians of functions which are more easily and appropriately rendered by other health practitioners on a more cost-effective basis, ASMT is strongly persuaded that much more can and should be done to insure that each practitioner works at the highest level of his/her competence. We do not believe that our current health care system, either from the perspective of the private or public sector, conscientiously practices this philosophy.

2. Increased emphasis on outpatient care.

Hospitals should be required to make provisions for one-day minor surgery and such concepts as "surgicenters" should be closely monitored and encouraged if warranted. Another area

which needs further exploration is preadmission testing. Such testing is now utilized by a majority of Blue Cross plans which pay for laboratory tests and x-rays if they are preparatory to admission and done in a hospital out-patient department. According to Blue Cross, this procedure has cut patient stays by one to two days.

3. Greater utilization of home health care services.

Recent studies have pointed to the fact that up to 25% of elderly patients in hospitals and nursing homes are institutionalized for reasons other than illness. Moreover, even the American Hospital Association concedes that six percent of all hospitalized patients could be discharged earlier. While significant savings could accrue with greater emphasis on home health services, only a small fraction of hospitals even operate home health care programs. While an increasing number of Blue Cross plans are offering home care benefits, the Federal government itself lags behind in this important area. Medicare now covers home care costs only after hospitalization and permits coverage only up to 100 visits. Furthermore, Medicare excludes qualified proprietary agencies from serving as primary providers of home care unless state law specifically permits them to participate. Given the large gaps in Federal recognition of home health care, ASMT recommends that Congress explicitly expand coverage of such services under Federal health programs.

4. Additional public and private support for consumer health education and a more intensive commitment to preventive health care.

One of the most obvious ways of cutting hospital use is to encourage individuals to be more responsible for their own health. In essence, additional health services do not always necessarily result in better health. Such factors as faulty diet, personal hygiene, exercise and emotional stress can and do lead to premature illness. While Congress has recently begun emphasizing primary and preventive medicine it has not yet made the type of national commitment which is required. For example, last June Congress passed P.L.94-317, the National Health Promotion and Disease Prevention Act of 1976 and although this was a significant step in recognizing the issue, little or no funds have been appropriated to date by way of implementing key portions of this legislation.

ASMT believes that the time has come for both the public and private sectors to jointly commit themselves to an activist approach in the crucial areas of consumer health education and preventive health care.

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

In response to the proposed Hospital Cost Containment Act of 1977, the American Society for Medical Technology:

...believes the legislation provides an excellent opportunity to engage in meaningful dialogue on necessary basic reforms in the current health care system.

...endorses the basic intent of the proposal, but does not support the specific methodology employed within the legislation.

...believes that capricious cuts would be both detrimental to immediate patient care and clinical education programs within hospitals.

...disagrees with the legislation's lack of positive incentives to encourage voluntary efforts which would contain costs.

...believes the proposal holds the potential to restrict quality hospital care, especially in services provided by non-physician personnel.

...views the "cap" concept as arbitrary as it tends to penalize efficient institutions while rewarding inefficient operations.

...believes it is preferable to develop basic structural changes in hospital and practitioner reimbursement as soon as possible rather than the legislation's proposed transitional plan.

...recommends that an acceptable method be developed for containing costs incurred by hospitals from outside suppliers.

...endorses proposed limitation on capital expenditures and certificate of need.

Statement

of

The American Society of Hospital Pharmacists

Before the

Subcommittee on Health and Scientific Research

of

The Committee on Human Resources

on

The Hospital Cost Containment Act of 1977

May 30, 1977

American Society of Hospital Pharmacists
Joseph A. Oddis, Sc. D.
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Chairman Kennedy, Members of the Subcommittee on Health and Scientific Research of the Committee on Human Resources.

The American Society of Hospital Pharmacists appreciates the opportunity afforded it to set forth its views on S. 1391, the Hospital Cost Containment Act of 1977. The Society is the national professional organization of pharmacists practicing in hospitals and other organized health care settings. Our membership is located throughout the United States and currently exceeds 15,000.

Although the ultimate responsibility and obligation to control costs rests with the hospital, - the professionals which use hospital services - physicians - and the professionals who deliver health care services on behalf of the hospital - pharmacists, nurses, etc. - all have a responsibility to assure that only services necessary to the care of a patient are used and that when necessary those services are delivered as effectively as possible. These responsibilities are familiar to hospital pharmacy. For years hospital pharmacists have been implementing programs which are both cost-effective and cost-reducing and which provide better patient care; however, many of these classes of programs have not been completely implemented in all hospitals or have not been implemented at all in some hospitals. The Society believes the full implementation of these cost-limiting pharmacy programs will have a material impact on reducing hospital costs [1] while concurrently improving

(1) Pharmacy operating costs currently constitute 6-8% of a hospital's operating budget. This figure rises to 10-12% if the costs of the entire drug distribution system (such as nursing time spent dispensing drugs) are included. Controller General's Study of Health Facilities Construction Costs, November 20, 1972. Page 479. A more cost-efficient drug distribution and drug utilization system could reduce hospital operating costs substantially.

patient care.

The Society's current concern is that S. 1391 may unnecessarily and unintentionally inhibit implementation of many cost-limiting pharmacy programs and services. While it is doubtful that such well established programs such as the hospital formulary system (which substantially reduces drug costs without any compromise to patient care) will be compromised by S. 1391, the Society is concerned that newer services such as unit dose drug distribution systems, clinical pharmacy services and centralized intravenous admixture programs, will be eliminated as hospitals strive to limit costs. The Society believes that such would be most unfortunate because these programs are cost-effective and provide improved patient care. Accordingly, we urge that the Committee provide clear direction to the Department of Health, Education and Welfare, state planning agencies and the hospital industry itself to encourage or mandate, on a priority basis, implementation and expansion of pharmacy programs which can demonstrate contained or lowered health care costs to the public.

Comment One: Over a decade ago the Society called upon the pharmacy profession and hospitals to charge for services based upon the cost of such service and to eliminate use of pharmacy charges to cover the cost of nonpharmacy activities. In April, 1966 the ASHP House of Delegates voted to encourage use of a professional fee, which would reflect the cost of pharmacy services, plus the net acquisition cost of the drug in calculating hospital "drug and pharmacy" charges. Since 1967 the Society and the Joint Committee of the American Society of Hospital Pharmacists and the American Hospital Association have recommended that this policy be adopted as an industry wide standard and although consistent with the AHA Statement on Financial Requirements of Health Care Institutions and Services, this

recommended policy has not been specifically applied to pharmaceutical services.

The 1966 ASHP policy, which requires a clear allocation of costs of pharmaceutical and other services represented in a hospital's "drug and pharmacy" charges, parallels the disclosure requirements of Section 125(a)(1) of S.1391; we still believe that accurate cost allocation throughout the hospital is desirable so that the public can evaluate whether a hospital service is justified, based upon cost. Accordingly, we recommend public disclosure of both the charges and the actual cost of the ten (10) most frequently used hospital services and explanation of any significant deviation between costs and charges.

Comment Two: Section 2 of S.1391 contemplates more permanent reforms for improved delivery and financing of health care. Although the comprehensive pharmacy services discussed below will certainly be a part of permanent reform, cost savings to a hospital through implementation of a comprehensive pharmacy service can be achieved now through action by individual hospitals without regard to permanent types of reform contemplated by this cost containing legislation. Efficient operation of a hospital formulary system, use of a unit dose drug distribution system, provision of clinical pharmacy services and operation of a centralized pharmacy I.V. admixture program are all examples of how pharmacy services can actually save a hospital money and provide better patient care.

(a) The Hospital Formulary System, operated by hospital pharmacists for over one hundred and fifty years, is probably the oldest hospital cost containment program. Under the hospital formulary concept, only those therapeutic agents and dosage forms deemed most useful in patient care, giving due regard to both quality and cost, are available in the

institution.[2] The system is dynamic to reflect current clinical developments and is an essential element in effective utilization review, control of drug costs and rational prescribing by physicians.[3]

The hospital formulary concept obtained general acceptance in hospitals approximately twenty years ago, when the ASHP adopted its "Statement of Guiding Principles on the Operation of the Hospital Formulary System". The Formulary Statement was approved by the American Hospital Association in 1960 and by the American Medical Association and American Pharmaceutical Association in 1964. Since then, the hospital formulary system has gained universal acceptance in organized health care; it is an extremely rare institution today that does not operate using the hospital formulary system.

The hospital formulary system is an outstanding example of a little known but long standing cost containment program. A conservative, but realistic estimate of the annual savings on single and multisource drug costs under the hospital formulary system is approximately 17%. Over the next several years, with the expiration of patent protection on many drugs and FDA bioavailability and bioequivalency regulations now in effect, the annual estimates rise to 21% or more, 40.4% on multisource drugs.[4]

Existing cost control features in the hospital formulary have been improved upon by hospital pharmacists in recent years. Hospital pharmacists have "tightened" formularies, restricting long duplicative lists of equivalent products to efficient compilations of single therapeutic agents necessary and useful in patient care. In some institutions the formulary is

(2) See Generally, ASHP Statement of Guiding Principles on the Operation of the Hospital Formulary System.

(3) Final Report, Task Force on Prescription Drugs. Page 40.

(4) Swift and Ryan, Potential Economic Effects of a Brand Standardization Policy in a 1000-Bed Hospital, Am. J. Hosp. Pharm. 32: 1247-1250 (December) 1975.

used to replace several drugs with one therapeutically equivalent drug.

Swift, supra, documented a reduction from $86,986.51 to $35,141.38 per year in drug usage costs and a reduction of 70.8% in inventory costs when fifty multisource drugs were standardized. (Savings would increase as more brands were standardized and/or several generic products replaced with one therapeutically equivalent product). In order to implement such potential savings, pharmacists in 67% of our nation's hospitals, (approximately 3,700 institutions) have the authority to select brands for the formulary and suppliers (to negotiate better prices).[5] Furthermore, 41% of hospitals (approximately 3,200 institutions) currently enjoy the economic benefits of group purchasing programs.

(b) The Unit Dose Drug Distribution System, one of three types of drug distribution systems[6], is an essential element in cost reduction through comprehensive pharmaceutical services. The unit dose drug distribution system (hereafter, unit dose system) is also recognized as superior in its ability to act as a tool in better patient care.

Under the unit dose system the physician's drug order is sent to the pharmacy where the order is filled and the necessary individually packaged and labeled drug for that patient is sent to the patient care area when it is time to be administered. Drug orders are reviewed and noted on a patient's medication profile which facilitates review and monitoring of therapy by

(5) Stolar, National Survey of Selected Hospital Pharmacy Practices, Am. J. Hosp. Pharm. 33: 225-230 (March) 1976.

(6) In addition to the unit dose drug distribution system, the other systems are the individual prescription system, where inpatient drug orders are filled as individual prescriptions much as a patient would get a prescription from a community pharmacy, and the ward stock system, where the pharmacy prestocks nursing units with "standard" drugs which the nurse selects and administers on a physician's order. Both of these systems allow many opportunities for medication errors to occur.

pharmacists who can check questionable orders with a physician and make adjustments or modifications to an order as indicated. Many nonjudgmental tasks in the system can be handled by trained technicians, freeing the pharmacist for those activities which require professional judgment. Because drugs are individually packaged, drugs which are refused or not administered can be returned to the pharmacy and to stock.

The advantages of the unit dose system as an efficient, patient oriented tool are well documented. As summarized by the Controller General's report, "Potentially Dangerous Drugs Missing in VA Hospitals-A Different Pharmacy System Needed" (Sep. 30, 1975) the advantages of a unit dose system over other drug distribution systems are:

--Less pilferage as large quantities of drugs are not stored in nursing areas;
--Less waste as unused drugs can be returned;
--Less nursing errors;
--More effective and safer drug therapy since patient profiles permit monitoring of therapy;
--More time for nurses to devote to patient care;
--More quality control as drug orders are reviewed by a pharmacist.

One of the more important "patient care" aspects of the unit dose system is its ability to significantly reduce medication errors. One study showed a significant decrease in rates of medication errors when the three drug distribution systems are compared[7]:

Hospital and Type	System	Error Percentage
A - Community	Prescription	8.3
B - Community	Prescription	9.9
C - University	Floor Stock	11.5
D - University	Prescription	20.6
E - University	Unit Dose	3.5

Other studies show similarly favorable results.[8]

(7) Hynniman, et al, A Comparison of Medication Errors Under the University of Kentucky Unit Dose System and Traditional Drug Distribution Systems in Four Hospitals, Am. J. Hosp. Pharm. 27: 803 (Oct.) 1970.

(8) See, e.g., Schultz, et al, Medication Errors Reduced by Unit Dose. Hospitals, J.A.H.A. 47: 106 (Mar.) 1973, which found error rates of 13.3 & 13.9% in traditional hospitals and rates of 1.9, 3.52 and 5.88% in hospitals using the unit dose system.

In addition to providing better care, the unit dose system is unquestionably cost limiting for both small[9], medium[10] and large[11] hospitals. One study found unit dose systems saved $0.3189 per dose ($37,470.90) in labor with a corresponding increase in pharmacy labor of only $11,749.35 and a one time equipment expense of $25,600. Andriole, dealing with a 331 bed acute care hospital with 110,000 prescriptions annually found unit dose systems savings to be substantial, but to level off; his findings are:

	Year 1	Year 2	Year 3
Unit Dose	87,945*	71,867	75,449
Cost Operations	109,277	114,943	120,187
Savings	21,332	43,076	44,738

*Includes 19,500 in new equipment

Andriole's savings translate to 1.7 nurses in year one, 3.2 nurses in year two and 3.1 nurses in year three; these are nurses who could have been assigned to patient care duties or not hired by the hospital. Yorio's study of a 630 bed hospital found a net savings of $0.17 per patient day or $0.78 per dose when using a unit dose, as compared to a traditional drug distribution system; with drug costs the savings per patient day is $0.23. The following are Yorio's calculations as to the cost of drug administration per patient day under both traditional and unit dose systems:

Traditional		Unit Dose
Pharmacy:	1.32	1.63
Nursing:	1.99	1.49
Equipment:	0	0.02
	$3.31	$3.14

Five Year life and 90% hospital occupancy

(9) Hendrix, The Administrator of a Small Hospital looks at Unit Dose Systems, Hosp. Form. Mgt. Feb., 1973

(10) Andriole, Unit Dose Savings Reach Plateau, Hospitals, J.A.H.A. 46: 116 (Oct.) 1972

(11) Yorio, et al, Cost Comparisons of Decentralized Unit Dose and Traditional Pharmacy Services in a Six-Hundred Bed Hospital Am. J. Hosp. Pharm. 29: 922 (Nov.) 1972.

Congress' own accountants, the General Accounting Office also concluded that the unit dose system is the cheapest system in terms of overall cost[12]. Though recognizing that pharmacy costs will increase under this system, the GAO felt such increase was more than offset in reduced nursing labor costs. The GAO study provided an extremely comprehensive study of a medium size, 250 bed hospital to determine the best pharmacy system. After reviewing operating, equipment and construction costs[13], the GAO concluded:

> Based on the results of the life-cycle cost/benefit analysis, the recommended pharmacy system for the reference hospital is the unit dose drug distribution system when savings in nursing time are considered. The analysis indicated that this system has the lowest life-cycle cost of all the systems evaluated in all discount and inflation rate combinations tested plus the benefits of lower dosage error rates and increased patient charting accuracy.

While the health and financial benefits of a unit dose system are clear, the hospitals of our country have not moved rapidly enough to implement this pharmacy activity. As of 1975, only 17.5% of our hospitals (approximately 950 institutions) had fully implemented (i.e., implemented in 90% or more of beds) the system and only another 10.2% of our hospitals (approximately 550 institutions) had partially implemented the system[14]. With only 28% of our

(12) Study of Health Facilities Construction Costs (Nov., 1972) P. 545. Accord, Potentially Dangerous Drugs Missing in U.S. Hospitals

(13) The GAO's staffing estimates were:

	Mechanical		Ward Stock		Unit Dose	
	1971	1996	1971	1996	1971	1996
Pharmacists	4	6	4	6	6	7
Technicians	1	2	2	4	4	8
Nurses	13.3	24.7	14	26.1	6.5	12.2
Nurses Aids	1.3	2.5	13.1	2.1	0.4	0.8
Cost	$268,759	474,321	286,029	508,861	233,345	367,688

Total life cycle cost* (in millions) was:

	Total	Labor	Drugs	Inv.	Misc.
Ward	9.34	5.59	3.40	0.14	0.19
Mech.	9.10	5.24	3.41	0.25	0.20
Unit Dose	8.04	4.26	3.37	0.16	0.25

*Adjusted to 1971 dollars over 25 years

(14) Stolar, supra n.5.

hospital beds served even partially by a unit dose system, we believe that high priority must be given to providing the health and economic benefits of this service to every bed for which it is feasible.

(c) Clinical Pharmacy services is a new concept in health care in which a pharmacist applies his extensive expertise on drugs to their clinical use in treating a patient. Although the precise parameters of clinical pharmacy services are still being defined, reflecting the diversity of needs of patients, other professionals and institutions, this activity includes:

Medication History: A pharmacist will take a comprehensive patient medication history on admission to determine allergies, sensitivities, potential adverse drug reactions and interactions, to determine which drug therapy must be continued during a hospital stay. Studies have shown that pharmacists do this important task far more effectively than others.

Patient Education: Poor compliance with drug therapy is a major health problem. Studies have estimated noncompliance as ranging from 4% (T.B. outpatients) to 92% (pediatrics) and 35% nationwide(15). Pharmacists education of patients about their illness, drugs and therapy is directly related to increased compliance(16).

Drug Therapy Consultation and Drug Information: Providing objective information about drugs to health professionals is particularly important in light of the proliferation of new drugs, dosage forms and uses and is a component of clinical pharmacy services. Clinical Pharmacy services also provide patient related drug information designed to promote rational drug therapy; establishment of dosing parameters, protecting against adverse drug reactions and drug interactions, advising on inappropriate concurrent prescribing and routes of administration, etc. are all services provided by clinical pharmacists.

(15) Sharpe and Mikeal, Patient Compliance With Antibiotic Regimens, Am. J. Hosp. Pharm. 31: 479 (May) 1974.

(16) Ibid. Chubb and Winship, The Pharmacists Role in Preventing Medication Errors Made by Cardiac and Hyperlipoproteinemia. Drug Intel and Cl. Pharm 8: 430 (July 1974).

The significance of these services cannot be understated since hospital patients receive 9.3-12.3 drugs during a stay[17] and medication errors may run as high as 18%; they may run as high as 21% in parenterals.

Precise valuation of clinical pharmacy is difficult because the outcome of this service--better care--is difficult to measure[18]. The cost of these services however, is measurable; it is $1.09 per patient day based upon a ratio of one clinical pharmacist to 35.4 patients. The costs of these activities are detailed below:[19]

Service	Cost Per Day	Per Function
Therapy Review (a) chart review	$28.28	0.62
(b) patient int.	2.35	0.70
Drug Information	4.58	1.27
Medication History	1.68	1.54
Discharge Consultation	0.62	0.62

Clinical pharmacy services function as an integral part of the unit dose system; they are the more professional, judgmental activities to which a pharmacist may turn under this system. As the bridge between clinical pharmacology and clinical medicine, these essential pharmacy services are low in cost, yet provide an incalculable benefit to the public in terms of better patient care.

Clinical pharmacy services are most often found in larger teaching hospitals. These services must begin to be implemented at the smaller community hospital where the lower level of sophistication of practice may require the drug expertise of the clinical pharmacist. We urge that the Committees recommend implementation of clinical pharmacy services as a low

(17) See n. 16, supra.

(18) But see Smith, infra n. 24 for cost effectiveness of these services.

(19) Schwartz and Swanson, Clinical Pharmacy Services II: Cost and Contributions of Four Clinical Pharmacy Activities Hosp. Pharm. Jan., 1976

cost activity which can control irrational use of drugs and provide clearly beneficial patient care services.

(d) Intravenous Admixture Programs Centralized in the Pharmacy is a logical extension of the unit dose system. Estimates indicate that an investment of as little as $1,000.00 and a realignment of nursing and pharmacy functions can place preparation of IV additive fluids in pharmacy. Thus, for a very small investment the expertise and knowledge of a pharmacist (the one person specifically qualified by education to compound drugs), the sterile environment available in a pharmacy and the economics of scale can be brought to bear on parenteral drug use in patients.

The benefits to patient care arising from a pharmacy based centralized IV admixture program are clear. Parenteral products mixed by nurses have a 21% error rate; 3% involved the wrong drug or solution, 9% involved the wrong dosage, 3% involved an unordered drug and 6% had drug incompatibilities[20] The Thur study also documented serious problems of technique in nurse prepared additives[21]:

Preparation in unclean work area	99%
Preparation without washing hands	97%
Sterile areas touched	4%
Vial tops not cleaned	31%
Sterile area of syringe touched	47%
Parenteral container not closed after preparation	23%

A centralized pharmacy IV admixture program, implemented as part of an overall unit dose program, involves an expense that is de minimus but which provides materially better patient care[22]. One study of a 500 bed hospital

(20) Thur, et al. Medication Errors in a Nurse-Controlled Parenteral Admixture Program. Am. J. Hosp. Pharm. 29: 298 (Apr.) 1972

(21) Ibid.

(22) See, National Coordinating Committee on Large Volume Parenterals, Recommended Methods for Compounding Intravenous Admixtures in Hospitals, Am. J. Hosp. Pharm. 33: 261 (March) 1976.

projected a 26% annual net savings in labor cost when parenterals are prepared in the pharmacy rather than prepared by nurses[23]. We believe that the central IV program is clearly something that must be encouraged.

* * * * * * * * * * * *

The services just described - the unit dose drug distribution system, clinical pharmacy services and central IV admixture programs - should be viewed as part of a comprehensive cost-effective pharmacy service. A study of comprehensive pharmacy services by the management consulting firm of Booz, Allen and Hamilton, Inc. found them to reduce costs in 15 of 19 hospitals studied[24] by $0.079 to $1.25 per patient day. A summary of the study is set forth below:

			Cost difference per patient/day (in dollars)				
Bed size category	Number of hospitals	Average bed size	Pharmacy Personnel	Nursing Personnel	Materials	Equipment	Overall
100 beds or less	1	62	-0.164	-1.165	0.128	0.229	-0.970
101 to 300	8	184	0.492	-1.124	0.140	0.066	-0.426
301 to 500	8	373	0.851	-1.354	0.146	0.054	-0.303
501 beds or more	2	652	0.627	-1.155	0.153	0.058	-0.317

Smith[25], on a government funded project, also found comprehensive pharmacy services cost $1.11 per patient day, saves $1.63 per patient day, netting $0.52 per patient day ($98,900 per year in a 680 bed hospital). Comprehensive pharmacy services are better patient care and less expensive patient care.

The American Society of Hospital Pharmacists recognizes that no health

(23) Ibitoye, Time and Motion Study and Cost Comparison Between Pharmacy Prepared and Nursing Prepared IV Admixtures, (Dec.) 1975. (Thesis-University of Kansas)

(24) Marshall, Clinical Program May Effect Savings Hospitals, J.A.H.A. 48: 79 (Dec.) 1974.

(25) Smith, The Economic Feasibility of Clinical Pharmacy In Hospital Setting. U.S. Department of Commerce, NTIS.

care group can speak of better care without speaking of lower, or limited costs to patients. It is time for us all to place less emphasis on expensive, glamorous care in favor of services that improve care for the majority while placing limits on health care costs. We believe that the comprehensive services we have outlined, services which now exist and are being provided to some, although not glamorous, meet these criteria and must be implemented as a high priority by all hospitals and given special consideration by the government.

Chairman Kennedy, Members of the Committee, this concludes our formal statement. We offer our offices, our expertise and that of our membership to help find a meaningful, workable solution to this very complex problem.

Thank you.



President
WILLIAM P. DAINES, MD
Ogden, Utah

President-Elect
BEN D. HALL, MD
Johnson City, Tennessee

Secretary-Treasurer
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Boulder, Colorado

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Skokie, Illinois

Executive Director
WILLIAM R. RAMSEY

Twenty-Second Annual Meeting
San Francisco, California
May 4-7, 1978

June 21, 1977

Stuart Shapiro, MD
Subcommittee on Health and
Scientific Research
Committee on Human Resources
United States Senate
Washington, D.C. 20510

Dear Dr. Shapiro:

Please find enclosed copies of the statement of the American Society of Internal Medicine on the Hospital Cost Containment Act of 1977, S. 1391. We respectfully request that it be included in the written record of the hearings.

Sincerely yours,

William P. Daines, MD

William P. Daines, MD

WPD:jas
Enclosures

535 CENTRAL TOWER BUILDING, 703 MARKET ST., SAN FRANCISCO, CA 94103 (415) 777-1000

Statement of

The AMERICAN SOCIETY OF INTERNAL MEDICINE
on the
Hospital Cost Containment Act of 1977, S. 1391

presented to the
Subcommittee on Health and Scientific Research,
Committee on Human Resources

June 1977

The increasing cost of medical care delivered in the hospital setting is a concern to all citizens, patients and physicians. The American Society of Internal Medicine agrees that it is necessary to address hospital cost reimbursement methods and supports the goal of cost containment. However, it cannot support the proposal set forth in the Hospital Cost Containment Act of 1977, S. 1391.

You have heard much testimony and received many statements identifying numerous problems with S. 1391, which would set a limitation on inpatient revenues and capital expenditures. Some objections have been broad--it is simplistic and arbitrary, it lacks incentives, and it is a short-term plan when a long-term solution is needed. Other criticisms have been more specific--the proposal rewards inefficiency and punishes the most efficient hospitals, it does not adequately take into consideration increasing costs for energy and medical liability premiums, and its arbitrary nine percent limit on inpatient revenues would force many, if not most hospitals, to apply for exceptions through a process that undoubtedly would be burdensome and complex. We believe most of these complaints are valid and share the concerns expressed. They certainly cast doubt on the likelihood that S. 1391 could fulfill its stated purpose of eliminating hospital inefficiency without affecting the quality and availability of services. And it is the bill's

effect on the quality and availability of medical care services in the hospital setting that concerns us most.

Proponents of the bill have asserted that it will not affect the quality or availability of care. Part of the rationale is that "more is not better." This is admittedly true in some instances, but, when quality and availability are considered, more is often better.

S. 1391 sets an arbitrary limit on inpatient revenues; it allows adjustments for changes in patient load only when the changes reach certain arbitrarily set levels; it allows pass-through adjustments for wage increases but does not recognize exceptional increases in energy costs, medical liability costs, supply costs, etc.; and, most importantly, it does not recognize the current efficiency level of individual hospitals. It defies reason that such provisions applied across-the-board would, in each individual institution, reduce only costs generated by inefficiencies without adversely affecting the quality and availability of services. We believe they would not. To suggest the contrary is at best misleading to the American people.

Our concerns about the bill's effect on the quality of services applies to future medical advances as well. Take for example, the patient with coronary artery disease, who may be managed in 1977 with a variety of complex services and may receive open heart surgery. The same patient in 1965 was observed in a general hospital setting with limited therapy other than medication. A decrease in coronary artery disease mortality has occurred--but the cost of accepted treatment is much greater. Consider also patients with certain lymphomas and leukemias that were virtually always fatal in 1965;

now remission can be achieved in a majority of cases. Treating these patients involves complex drug treatment protocols, multiple complications from the complex therapy, transfusions of blood and blood products, and the threat of high mortality for patients not monitored carefully. But again, cost in 1977 for treating these patients is far greater than in 1965. We believe that medical advances such as these and the resultant improvements in patient care, especially those in chronic diseases, would be inhibited by an arbitrary limit on the inpatient revenues. This is particularly true since, by definition, the allowable increase would decrease each year. New medical advances would be limited solely because of cost considerations, without regard to their desirability.

The concerns we expressed above on the inpatient revenue limitation apply equally to the capital expenditure limit. It places an artificial nationwide limit on capital expenditures, which would be apportioned among the states initially on the basis of population. Both the limit and the allocation of funds would be determined, again, without regard to the effects on quality and availability or to the actual need for capital expenditures for expansion and modernization. Further, it represents more federal intrusion into the local health planning process and, of course, local decision-making is the underlying principle of the National Health Planning and Resources Development Act of 1974.

In short, we believe S. 1391 will adversely affect quality and availability of medical care services in the hospital setting, present and future. As we have stated in the past, it is inadvisable to consider separately the attributes of our health care system--quality, availability, and cost.

It is imperative that they be considered together if we are to plan rationally for the future. We share the growing concern about hospital costs increasing faster than the general inflation rate. But it also must be recognized that implementation of medical technological advances and increases in the availability of services demanded by the public cannot be accomplished without substantial increases in cost. The public may decide it wants to trade off quality and availability in order to reduce costs. But, certainly, the options should be presented to the American people in this, their true, context.

ASIM recognizes the need for addressing the problem of hospital costs expenditiously. However, we are not convinced that a "transitional" (short-term) approach is necessary or advisable. Imposing a short-term plan, especially one based on arbitrary limits on revenues and capital expenditures, then switching to another approach in two or three years may be chaotic for the hospital industry. What is needed is a carefully considered, comprehensive approach which addresses more than reimbursement methods. And we believe such an approach must provide for the following in order to assure that our medical care dollars are expended in the most cost effective way:

1) Consideration of the quality and availability of services. To consider cost alone would be a grave disservice to the American people.

2) Positive incentives for efficiency. The system should encourage making the right decisions for the right reasons.

3) Recognition of the current efficiency levels of individual hospitals. It is unfair and unwise for the government to reward past inefficiency and punish past efficiency.

4) Encouragement and support of current cost containment efforts. We must allow health planning, alternative delivery systems, and utilization review to evolve and be evaluated.

5) Local decision making. Federal edict would never adequately coincide with local needs and desires.

6) Optimum use of peer review. Concurrent review can help to control utilization, medical necessity, and serve the cause of quality medical care.

CONCLUSION

As a physician organization, we are attempting to stimulate a meaningful awareness of costs among our members, and properly so. However, we will never be able to accept cost as the sole or determining factor in decisions about medical care delivery. Therefore, the American Society of Internal Medicine opposes adoption of S. 1391 and will oppose any proposal to contain hospital costs through arbitrary limits set on revenues or capital expenditures. We could support a program that includes the six points we have outlined above.

jas
6/20/77

asim
american society of internal medicine
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ALFRED M. BELL
PRESIDENT

HEALTH & WELFARE TRUST FUNDS
PENSION TRUST FUNDS

June 16, 1977

The Honorable Edward Kennedy
The United States Senate
Washington, D. C. 20510

Dear Senator Kennedy,

I have learned from testifying when you chair hearings that the most valuable portions are the exchanges of questions and answers. I regret, therefor, that this time it is not possible to do more than provide the attached statement for the record on S.1391. My staff called several weeks ago and requested time for a personal appearance. This week we learned that your witness list was closed.

I would be grateful to you and your subcommittee for any consideration of the amendments that are enclosed.

If you can find time from what I know is a very busy schedule for you, I would be happy to arrange an appointment to further explain the impact of Federal health policy on Taft-Hartley trust funds.

Sincerely,

Alfred M. Bell

Alfred M. Bell

Enclosure: Statement on S.1391
with attached amendments

STATEMENT ON THE
HOSPITAL COST CONTAINMENT ACT OF 1977
(S.1391)

before the

SUBCOMMITTEE ON HEALTH

COMMITTEE ON HUMAN RESOURCES

U.S. SENATE

JUNE 20, 1977

by

ALFRED M. BELL

HEALTH PLAN ADMINISTRATOR

Amendments Attached

2021 L Street, N.W.
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Mr. Chairman and Members of the Subcommittee:

I am Alfred M. Bell, an administrator of Taft-Hartley health and welfare trust funds in the Washington, D. C. and Baltimore metropolitan areas and in Puerto Rico. The local trust funds I represent serve approximately one-quarter of a million fund beneficiaries who reside and receive health services from providers in the States of Virginia and Maryland and the District of Columbia.

I am also a founding director and an officer of two national associations; the National Association of Professional Administrators and the National Association of Jointly Administered Trusts. Members of these associations collectively represent a majority of the Nation's Taft-Hartley trust funds.

My colleagues and I have a problem with S.1391. It is a simple one which we believe can be resolved by adoption of the amendments attached to this statement. Their intent is assurance that rates for inpatient hospital services will be set equitably among all purchasers without discrimination.

In using the term "equitable", we recognize payments can be in kind as well as cash. Actual cost savings afforded hospitals through the business practices and policies of the payor could be equitably tallied as a form of reimbursement by way of an equally proportionate rate differential.

There are three basic classes or types of health purchasers; the charge-basis purchaser, the cost-basis purchaser and the capitation-basis purchaser. Of the three, the bill (S.1391) discriminates in favor of the last two and against the first. Of the three, only the charge-basis purchaser lacks

the near monopoly power over hospital charges exercised by the other two.

Blue Cross represents health providers. HMO's represent health providers. Medicare and Medicaid represent government programs. Blue Cross, Medicare and Medicaid are cost-basis payors. HMO's, for the purposes of section 121 (b)(3) of the bill, are capitation-basis payors. Most other purchasers of hospital services are charge-basis payors.

Section 101 reads in part: "--to constrain the rate of increases--by limiting the amount of revenue which may be received, by the hospitals involved, from Government programs, private insurers, and individuals who pay directly for such care." There is no further reference in the bill to private insurers or individuals. Cost and capitation-basis payors are defined.

Labor, industry and private insurers are the three basic groups that make-up Taft-Hartley trust funds. Labor and industry are the instruments through which all health purchase funds are obtained whether they be expended by way of taxes, payroll deductions, purchase of an underwriter's premiums, or direct payment to providers. They should be treated equitably without discrimination as compared to other classes or types of purchasers when they become consumers of the services which their funds have purchased.

Administrators of Taft-Hartley trust funds adjudicate and pay health claims. Of major concern to us are two developing problems. One is the number and cost of unnecessary and defensive procedures practiced by hospitals and doctors. The other is our involuntary subsidization of the cost-basis purchaser (Blue Cross, Medicare and Medicaid) which we see as a major cause of the inflationary spiral of health care costs for trust fund beneficiaries.

When Medicare, Medicaid and CHAMPUS became dominate purchasers of health services our costs went up immediately. Rates for some health services increased by as much as 75 per cent.

To illustrate our present problem, consider that in the home state of Senator Williams, Chairman of the Committee of which this Subcommittee is a part, the New Jersey Hospital Association tells us hospitals are reimbursed on a cost basis not a charge basis for approximately 85 per cent of their patients (Medicare, Medicaid, CHAMPUS and Blue Cross). Since only 15¢ of every $1 is received from purchasers who are not on a cost basis, room and board rates, or any other increase, must be increased by $6 to realize $1 in increased costs.

The laboring men and women of this Country agreed to pay taxes to provide our disabled and aged with the health care they need. They expected that health claims of their more distressed neighbors when submitted in compliance with law would be paid in full. They are not.

Medicare, Medicaid and CHAMPUS pay significantly less than the full financial requirements of health providers. Under the California Medicaid program, for example, physician's fees were frozen for many years at the 60th percentile of the pre - 1968 fee levels. These deficits were passed on in higher costs to charge-basis payors. That's us. We didn't like it and don't like it. We have to give up eating, or rent, or something else, to make up the difference. It is an unduly discriminatory situation we face daily.

S.1391 was designed as a transistional bill. However, Section 102 (f) gives its substance a degree of permanance by granting to the States the option of taking over the Federal burden assumed by passage of the bill.

The Maryland Health Service Cost Review Commission would appear to be a prototype of the State program encouraged by S.1391. Let's look at how it works.

The Maryland Commission determines what rates are reasonable for each hospital. Hospitals discovered overcharging, according to these rates, are audited. Any revenues discovered to be in amounts above the rates are recovered by the State.

Commission guidelines allow rate differentials. At present, Blue Cross is the only major payor given a rate differential. Federal authorities would have to provide a waiver in favor of the Commission before Medicare, Medicaid or CHAMPUS could come under its jurisdiction. S.1391 exempts Federal programs from those of its provisions which relate to State programs.

The result in either case is a continuation of the problem for charge-basis payors. The effect, also, is one that precludes any negotiation with the providers for rate relief. By setting a cap on rates and allowing a rate differential based on the cap, the resulting rate becomes both a maximum and a minimum rate. The charge-basis payors are boxed-in to an inflexible charge and one most difficult to monitor because rates are primarily based on department costs and have little or no relation to the benefit structures as traditionally designed by trustees of Taft-Hartley funds.

The power and impact of Federal programs on health providers is such that sponsors of S.1391 can feel confident the enforcement provisions of Section 116 will keep them in line. This section denies participation under Titles V, XVII and XIX of the Social Security Act to those providers

who choose not to comply with the other provisions of S.1391.

Despite its title "Hospital Cost Containment", S.1391 holds little promise for charge-basis payors. It only sets a cap on the percentage of increase that can be expected. For us, it does little if anything to truly contain the costs we will pay. Without amendment, S.1391 will continue and strengthen the favoritism of cost-basis purchaser. Charge-basis purchasers will have to make up the deficits resulting from any increased costs, and, at the 6 to 1 ratio described as the situation in New Jersey, it's rough. Most likely, most funds will have to further reduce or drop benefits from their health plans; an illogical result of Federal health policy.

In representing the charge-basis payor, we appear here on behalf of a majority of those who pay the Nations bills. It is ironic that we are reduced by Federal health policy to a weak minority in any bargaining for a hospital's attention.

In his April 25th message to Congress, in which President Carter transmitted his proposal for a hospital cost containment system, he said:

> "This proposal relies heavily on the initiatives of the private sector. For it to succeed, businesses, unions, and insurors working with providors, must continue to pursue innovative techniques for reducing the cost of high-quality health care. The private sector's response to the challenge of cost containment will help decide its future role in our health care system."

That portion of the private sector which I am privileged to represent will do its best in response to the challenge made to us in this message by our President. We will need some help from you. Please include and support the amendments we have proposed.

We ask only for fairness and equity for all health purchasers and that those of us serving health and welfare funds be allowed to perform according to the trust placed in us by our people.

Thank you for the opportunity to present this statement.

Subcommittee on Health,
Committee on Human Resources

AMENDMENTS TO S.1391
(The Hospital Cost Containment Act of 1977)

1. Insert the following, between lines 2 and 3 on page 3:

   "An additional, but no less important purpose of this title, is to assure all purchasers of inpatient hospital services that rates are set equitably among all purchasers without discrimination."

2. Delete the phrase "except the medicare program" from line 16 on page 5.

3. Delete the parens and the phrase "except revenues received under title XVIII of the Social Security Act" from lines 14 and 15 on page 18.

4. Insert the following, between lines 24 and 25 on page 18:

   "(5) The State program assures all purchasers of inpatient hospital services that rates are set equitably among all purchasers of services without discrimination."

5. Substitute a comma for the period on line 2 of page 25 and add the following:

   "and (c) submit a statement that its rates have been set equitably among all purchasers without discrimination."

6. Delete the phrase "of such hospital or hospitals for whom reimbursement at less than the inpatient charges (as defined in section 122(c) of this Act) applicable to such inpatients is anticipated, "and insert the word "charitable" to immediately precede the word "inpatients" on line 22 of page 25.

ASSOCIATION OF
REHABILITATION
FACILITIES

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Director
T. P. Hipkens

STATEMENT BY T. P. HIPKENS
DIRECTOR, ASSOCIATION OF REHABILITATION FACILITIES
SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH
OF
SENATE COMMITTEE ON HUMAN RESOURCES
JUNE 22, 1977

I represent the Association of Rehabilitation Facilities. ARF is the principal national membership organization of nonprofit medical and rehabilitation facilities. We have over 1,000 facilities which are members of ARF and its state affiliates. Of this total, approximately 100 are rehabilitation hospitals providing comprehensive programs for victims of traumatic injuries, stroke, neurological disease, spinal injuries and similiar diagnoses.

We present this testimony to the Committee to make two points concerning the President's hospital cost containment proposal. The first of these relates to coverage of the program and the second to the broader question of cost efficiency in health care.

COVERAGE

Section 111 of the bill defines the term "hospital" thereby establishing certain exemptions from the price control system otherwise applicable. Subsection 111(a)(2) exempts an institution which "has an average duration of stay of 30 days or less in the base accounting year." This provision is intended to exclude from the price control system facilities which are not acute care hospitals and which hospital characteristics are therefore unrelated to the norms and standards proposed in the bill. This is an appropriate approach since the bill does not provide for differentiation but rather subjects all covered facilities to a single price control system.

We can find no precedence in existing law or policy for the 30 day standard. It apparently is a horse back estimate of a fair dividing line between acute care facilities and other types of hospitals primarily in our judgement mental, chronic disease, and rehabilitation hospitals. We believe exclusion of rehabilitation hospitals from this legislation is appropriate. First, because of the nature of the patient population and treatment typical in rehabilitation hospitals. Secondly, because of the long term programs which are typical of such facilities there may be fluctuations in length of stay, greatly in excess of those experienced in acute care facilities and cost per admission may therefore also fluctuate substantially. Under these circumstances application of a cost control apparatus designed for acute care hospitals would be inappropriate.

From an informal survey of the number of rehabilitation hospitals we have determined that the average length of stay of most such facilities is close to the 30 day cutoff point.

We received returns from 54 hospitals of approximately one hundred and twenty five surveyed. Of these, 19 were rehabilitation units of acute care hospitals, 29 were free standing rehabilitation hospitals, and 6 were specialty programs treating children's disabilities, alcoholism and chronic diseases of the aged. The latter six institutions were not included since their length of stay was unusually long.

The 29 free standing rehabilitation hospitals reported a total 2,138 beds for an average size of 74 beds. The range was from 22 beds to 150 beds. The average length of stay for all of these institutions was 37 days. However, 10 or nearly 35% had an average length of stay of 30 days or under for the reporting year 1976. More than half of these reported an average length of stay of 27 days or longer.

Patient mix, e.g. an increase in a very few high spinal cord injured patients, will have a drastic effect on the average length of stay for a small facility.

The 19 units of acute care hospitals reported a total of 778 beds for an average of 41 beds. The range was from 16 beds to 142 beds. The average length of stay per facility was 33 days. Nine of the facilities or nearly 48% had an average length of stay of 30 days or under for the reporting year 1976.

If the 30 day standard is retained as an absolute means of exclusion, it would lead to a strange and inequitable conclusion. A number of rehabilitation hospitals with lengths of stay in 1976 of just under 30 days per admission would be subject to the terms of the Act while many similiar facilities with essentially identical programs would not be covered because their length of stay in 1976 was slightly above 30 days. We can perceive no valid public policy to be served by this effect.

Tentatively, we recommend however, that the problem can be solved by pegging the exclusion in Section 111(a)(2) of the bill at 25 days instead of 30 days. We do not believe this change would exempt any acute care hospitals.

Our concern about coverage does not flow from the assumption that costs in rehabilitation facilities are excessive, but rather that the imposition of a cost control system unrelated to such facilities will result in bureaucratic confusion and administrative waste.

HEALTH CARE COST CONTAINMENT

In a more general sense we are concerned that the President's proposal does not address a major cause of escalating health care costs. In support of the proposal it is submitted that hospitals have little incentive to contain cost because the bills are paid by third parties including Medicare and Medicaid. In fact, there is a strong bias in Medicare and Medicaid as well as Blue Cross and commercial insurance in favor of high-cost inpatient care. The programs operated under federal legislation and policies of commercial insurance generally are addressed to inpatient care and impose substantial limitations on outpatient coverage. The result is a clear incentive to inpatient utilization and expansion of facilities for inpatient care. Having promoted a reliance upon inpatient services the government is now concerned with restricting its costs through the kind of measure which is before this Committee.

Whether or not a 9% cap enforced by federal law is a legitimate means of containing health care costs we submit that this Committee and others concerned with containing health care costs should focus on the need for a wholesale revision in government practice and contracts of health insurance to promote outpatient services.

I would particularly commend to you the language contained in H.R. 6411 pending before the House Committee on Ways and Means. This bill which was introduced by Congressman Mikva would amend Title XVIII of the Social Security Act to provide coverage of comprehensive outpatient rehabilitation services. The law currently covers such services when rendered to inpatients and denies coverage to most outpatients. This type of incentive for inpatient utilization or inpatient services is at the heart of the health care cost problem in the United States. There are a number of bills to broaden and control home health services. More effective programs in this area would also help to reduce hospitilization.

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THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS

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Statement of

Jonathan E. Fielding, M.D.
in behalf of the
Association of State and Territorial Health Officials
before the
Subcommittee on Health
Committee on Ways and Means
and the
Subcommittee on Health and Environment
Committee on Interstate and Foreign Commerce
U. S. House of Representatives

May 11, 1977

My name is Jonathan Fielding. I am the Commissioner of Public Health in the Commonwealth of Massachusetts and wish to testify on behalf of the Association of State and Territorial Health Officials.

The Association, more commonly known as ASTHO, is strongly supportive of the basic thrust of the "Hospital Cost Containment Act of 1977" which is attempting to curtail hospital revenues and capital expenditures.

In making the comments that follow, we do wish to emphasize that we are giving due consideration to the Administration's clear statement that the legislation is being proposed on an interim basis and that the legislation does not, nor was it intended to, provide permanent solutions to all aspects of the problems associated with hospital costs.

The increase in expenditures in the health care delivery system over the past decade has not demonstrably benefited the health status of the population. We are increasing costs, expenditures and technology without a necessary relationship to improving health. In addition to putting a cap on the hospital side, consideration should be given to increasing our investment in the prevention of illness and the promotion of wellness.

Although we are supportive of the intentions of the legislation, we do have both procedural and substantive concerns with regard to the level of consultation with and participation from the States that is invisioned by the proposal. We recommend that the following roles should be delineated for the States.

First, the States should link and coordinate recommendations and findings from HSAs being transmitted to the Secretary of the Department of Health, Education and Welfare. A specific example of this concern is under Section 126, Improper Changes in Admission Practices. Under this section, when a written complaint by an institution is received that a hospital is changing its admission practices in a manner that would tend to reduce the proportion of in-patients for whom reimbursement is less than charges, a Health Systems Agency would make a finding based upon which the Secretary of D-HEW would institute a sanction. It is inappropriate that this activity be undertaken independent of the State in a direct relationship with the Secretary. Clearly, the State has a strong interest in assuring that the effect of regulation does not create inequities for its population. The State, therefore, has a strong interest in having the HSA make its recommendation through the State, or jointly with the State. We are not implying that the State's interest is overriding; we are, however, suggesting that the State does have a legitimate role and interest.

Second, the State should be asked to look at shifts in resources broader than the shifts in admission practices included in Section 126. All changes in hospital beds should be covered by the Certificate of Need provisions of the Act, as well as the changes in services already included. The State should also monitor shifts in resources among types of patients, so that they can prevent hospitals from discriminating against the poor or the handicapped in the name of cost control.

Third, the State should receive Federal financial assistance to collect data on hospital discharges, and other measures of hospital use, cost and expenditures, and outcomes. There is a need for strong Federal support and leadership to assure national consistency. These data will allow HSAs, States, and the Federal government to monitor this interim cost containment legislation toward strengthening and improving it based on experience and sound information. The data will also provide a baseline for the future planning of the allocation of hospital resources.

Fourth, the States should coordinate the flow of information from hospitals to HSAs. For example, the legislation requires the disclosure of fiscal information. Hospitals must report semi-annually the semi-private room rate and the charges for 10 other services which the Agency finds are most frequently used or important for cross-hospital comparisons, and make

available all cost reports submitted to cost payers. These data would be more useful if they could be amalgamated by the State. There should be common agreement on a State-wide basis as to the designation and definition of the 10 services to be covered. States should link this information with the State Medical Facilities Plans. For selected services, hospitals should be required to break out the professional fee component as an aid in understanding differences among hospitals.

Fifth, the provisions of this legislation should be linked with the State Medical Facilities Plan (SMFP) required under P.L. 93-641. We support the use of an absolute cap that would apply to all hospitals, but recognize the need for specific criteria that allow for variation. To the extent that exceptions are to be allowed, the State should be directly involved in those decisions as they relate to capital expenditures as well as revenues. The SMFP could and should provide the basis for exceptions required under the Act. If given sufficient resources, States could develop these plans rapidly and tie them to the State Health Plans also required under P.L. 93-641. This would provide an opportunity for States to indicate how they intend to meet the lower bed-to-population ratio established in the Act and how they intend to allocate resources for facilities where they are necessary.

We would suggest that there is a unique opportunity to incorporate this relationship into the interim proposal and give greater focus to future facilities development based planned projections over five or ten years. ASTHO wishes to generally emphasize that the States and the Health Systems Agencies are in a better position than the Federal government to make recommendations for exceptions since they are closer to the local situations.

Sixth, we support the exemption of States that have adequate cost controls in place and would encourage the funding of experiments in those States to provide guidance for the Federal program as it moves out of the interim phase. In addition, it is essential that States' capacities in the cost control area be strengthened through additional Federal support and technical assistance. Such support could include the sharing of the present State experiences and the provision of potential models. There are only five or six States that will potentially receive exemptions. The majority of States need assistance.

Seventh, we feel that States, much like the Federal government, need to coordinate their cost control efforts most effectively with other related activities in planning and policy development. The proposed legislation could be more supportive of such efforts by tying the States closely to the intent of the legislation. For example, States could be asked to submit administrative programs that would integrate cost control, planning and policy linkages at whatever level they might be currently operating. In some States, this would be the development of a strong capital expenditures control system while in others it would be a coordinated and complex system of rate setting, planning, and capital expenditures controls. This could be at least partially accomplished through a State administrative program requirement. Such a

In closing, I want to stress that the Commonwealth of Massachusetts strongly supports the intentions of the Act and feels enactment this year would be a giant step forward and a necessary underpinning for any national health care financing system.

I would be pleased to respond to any questions.

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June 20, 1977

Stuart Shapiro, M.D.
Subcommittee on Health and
Scientific Research
Committee on Human Resources
United States Senate
Washington, D.C. 20510

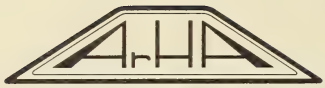
Dear Dr. Shapiro:

Enclosed is our testimony on The Hospital Cost Containment Act of 1977. This is transmitted to you for inclusion in the record of the committee hearings of the Subcommittee on Health and Scientific Research of the Committee on Human Resources on S 1391.

Sincerely,

Ronald D. Krause
Executive Director

Enclosure



ARIZONA HOSPITAL ASSOCIATION
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June 20, 1977

Honorable Edward M. Kennedy
Chairman, Subcommittee on Health
and Scientific Research of the
Committee on Human Resources
United States Senate
Washington, D.C. 20510

Dear Chairman Kennedy:

I would like to take this opportunity to express the official position of the Arizona Hospital Association on "The Hospital Cost Containment Act of 1977," S. 1391, and to ask that our testimony be included in the record for consideration by the committee hearings of the Subcommittee on Health and Scientific Research of the Committee on Human Resources.

For purposes of background perspective, the Arizona Hospital Association currently includes 63 member hospitals comprising 86% of the short-term beds in the state. The licensed hospitals not participating in our Association include many of the federal hospitals (public health service hospitals; military based hospitals), two state hospitals (crippled children's; state psychiatric hospital) and several small mining company owned hospitals. It is important to note that of our 63 members, 34 are hospitals with less than 100 beds and 20 of these have less than 50 beds.

ARIZONA HOSPITAL ASSOCIATION POSITION ON S. 1391

After considerable analysis of the effects the proposed legislation would have on Arizona's hospitals and the communities they serve, our membership has strongly and unanimously concluded that The Hospital Cost Containment Act of 1977 is unsound in premise and pernicious in its projected implementation. I would like to share with you the rationale for our position which revolves around three major components: the philosophical basis of the entire legislation, the projected financial effect on Arizona's hospitals, and the effect on Arizona's hospitals of a national capital expenditure limitation as embodied in Title II.

GENERAL PHILOSOPHICAL OPPOSITION

1. A single percent increase or cap on revenue for all institutions does not acknowledge or account for the great variations in patient mix, treatment and diagnostic capabilities, regional cost disparities and specialized community demands. The nature of Arizona's topography, environment, and growth has created great variances in these factors which would be virtually ignored by the legislation.

2. Imposing categorical ceilings while not controlling any of the myriad of factors which contribute to overall costs is without rational justification. The costs, for example, of wages, supplies, utilities, and malpractice premiums have in the last five years increased at an exponential rate.

3. The major elements responsible for rising hospital costs are not accounted for in S. 1391. The legislation concerns itself only with the end product--Hospital Costs--without any attention or acknowledgment of the factors which have led to increases. The net effect of this myopic thinking will be deterioration of the quality of care now available and discouragement of further medical progress.

4. The bill is so tremendously complex that it is unworkable and will create such large administrative and implementation costs that any theoretical cost savings would be neutralized.

5. The bill does not encourage innovative responsive management techniques. As drafted, those facilities which have streamlined their operations and effected cost savings, would be penalized by having to squeeze an already lean operation.

6. The proposed legislation does not adequately account for the totally unique environment in which the small rural hospital must operate. In Arizona more than half the hospitals are less than 100 beds and are usually the only source of institutional health services available for isolated communities. It is not inconceivable that many of these institutions would crumble under the restrictions imposed by S. 1391.

7. S. 1391 ignores community demands for availability of many costly services and programs. Medical technological advances are both miraculous and expensive and quickly become a part of the minimum acceptable standard of care the public expects.

8. The proposed legislation does not capitalize on or encourage the many cost savings programs in which hospitals are already involved. Programs such as the Cooperative Purchasing Association, Shared Clinical Engineering Services, and Management Engineering Services have already produced great cost savings for many of Arizona's hospitals.

FISCAL IMPLICATIONS

Although our strong opposition to The Hospital Cost Containment Act of 1977 is primarily based upon the underlying philosophies expounded in the legislation, we have also attempted to apply the various formulae contained in the bill to a sampling of our member hospitals in order to ascertain the theoretical financial effect. This process was greatly complicated by a lack of clarification on several major issues and thus, to some extent, we were forced to make our own assumptions.

Using a representative sampling of approximately 20% of our member hospitals, and assuming the bill in its current form became operational in October 1977, we have calculated that $42,400,000 of revenue would be disallowed to our 63 member hospitals during their first fiscal year affected by the legislation. This represents approximately 7% of the projected revenue for that period of time. For the past five years, Arizona's hospitals have been subjected to a legislatively enacted rate review program. This mandatory program, which includes two public hearings in front of local and state agencies, reviews in depth any increases in hospital charges and the justification for each. While conformance with the recommendations of the reviewing agencies is not mandatory, almost without exception since the program's enactment, hospitals have abided by their decisions.

The hospital rate review system in Arizona has received a great deal of positive national attention pertaining to its effectiveness, and based on the record to date, it can be said that hospital rates in Arizona accurately reflect operational costs. This record of performance definitely indicates that if hospitals in Arizona are disallowed $42,400,000 in revenue during their next fiscal year of operation, institutions will be forced to either thin the types of services which they currently offer, and which have been endorsed by the public through the mandatory certificate of need and rate review programs, or suffer a dilution in the quality of services now being rendered. It is hard for us to believe that Arizona's citizens will find this type of deterioration tolerable.

The fiscal prognosis of implementing The Hospital Cost Containment Act in Arizona only serves to further amplify the commitment of the Arizona Hospital Association and its individual members to totally oppose S. 1391.

TITLE II - LIMITATION ON CAPITAL EXPENDITURES

The need for inclusion in this legislation of Title II, the establishment of a national control and limitation on capital expenditures, remains to our member hospitals both an enigma and potentially the most dangerous component of S. 1391 by putting the future availability of hospital services to Arizona's citizens in jeopardy.

The Secretary has indicated that allocations for capital expenditures will be based on state population. States like Arizona with relatively small populations which are experiencing rapid growth would shortly become hard pressed to keep pace with community demands created by the ever increasing influx of people.

Irrespective of the continual requirement to modernize health care institutions in order to conform with the multitude of state and federal fire, safety and other codes, this type of categorical allotment is at best short-sighted and has the added potential of depriving the citizens of many areas of the country of access to modern health care technology. The legislation does not speak to whose responsibility it will be to inform those patients requiring expensive life support machinery that Arizona has used up its small quota for hospital capital expenditures and that additional equipment is not available this year.

But, what remains incomprehensible to our member institutions is the Administration's apparent total disregard of existing strong state certificate of need programs like Arizona's and the most comprehensive health planning legislation ever enacted, PL 93-641. The desire of the Congress, which three years ago opted to strengthen local control and public input into the health planning process, is now being redirected so that this authority will rest in the hands of one individual who could not be expected to understand the needs of each Health Systems Area.

The Arizona Hospital Association and its member hospitals have always supported comprehensive health planning based on local input and feel that Title II of S. 1391 undermines this entire process, ignores existing programs which have proven effective, and negates one of the major elements of Public Law 93-641.

The Arizona Hospital Association fully supports the position of the American Hospital Association which was presented at the May 26, 1977 hearing.

We recognize our responsibility to continue to seek new ways of controlling costs and have further mobilized the resources of our Association toward this effort. While we do not as yet have a universal answer, it remains quite clear to us that S. 1391 would only serve to further burden a system which is already heavily laden with duplicative, expensive and sometimes conflicting regulation.

The Arizona Hospital Association respectfully urges your consideration of our position during your deliberations on this bill.

Sincerely,

Ronald D. Krause
Executive Director

bjm

cc: Honorable Dennis DeConcini
Honorable Barry Goldwater
Honorable John Rhodes
Honorable Morris Udall
Honorable Eldon Rudd
Honorable Bob Stump
W. Austin Turner, president, Arizona Hospital Association
Leo J. Gehrig, M.D., senior vice president, American Hospital Association

THE CATHOLIC HOSPITAL ASSOCIATION
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STATEMENT OF THE CATHOLIC HOSPITAL ASSOCIATION
ON THE HOSPITAL COST CONTAINMENT ACT OF 1977 (S 1391)
BEFORE THE SUBCOMMITTEE ON HEALTH
AND SCIENTIFIC RESEARCH
COMMITTEE ON HUMAN RESOURCES, UNITED STATES SENATE

The Catholic Hospital Association represents nearly 900 Catholic Church related health care institutions in the United States. Our members sponsor or manage more than 160,000 acute care beds, making them the largest single sub-system of voluntary hospitals in the country. The history of the Catholic Church in health care delivery in this country pre-dates the Revolutionary War. Religious Sisters were among the first to open hospitals in the pioneer West and the Catholic Church through the efforts of hundreds of thousands of people including religious, clergy, and laity remain among those committed to operate needed health care facilities in the decaying core of our inner cities as well as in isolated rural areas.

We now, once again, reaffirm our commitment to our healing ministry and will continue our efforts to strengthen, improve, and reinforce the voluntary, pluralistic health care delivery system which we believe offers to Americans the highest quality and scope of health care services available in the world today. Our health ministry efforts are not

perfect; the health delivery industry is not perfect; and America is not perfect. We join with all who strive to improve the quality of life for all Americans. The desire to respond to human needs is our motivation; healing is our function; and the relief of suffering and illness is our goal.

Quality Health Care Services

The members of The Catholic Hospital Association have been among the leaders in the efforts to improve this system even more. One of our greatest concerns has been to maximize the quality of health care delivered to all citizens within reasonable and effective cost constraints. We were among the first hospital industry representives to endorse, for example, the concept of Universal National Health Insurance. We have repeatedly called for improvements in the Medicare and Medicaid programs, rural health, and health manpower education, and the availability of care and services.

Constraints and Limits

We have recognized, too, that the resources available for this purpose are limited. We have supported efforts to control the rapid rise in per service costs and we have endorsed programs to curb waste, duplication, and the proliferation of unnecessary services. The Catholic Hospital Association was among the first to support and promote comprehensive health planning, certificate of need, and utilization review. We once again reaffirm our support of these and other positive and constructive efforts.

S 1391

We cannot support S 1391. This is not a precipitious decision. We are concerned about the increase in health care costs, but after long and deliberate analysis and evalution, we concluded that S 1391 will not accomplish these purposes. On the contrary, we firmly believe that it will undermine many existing strengths and past achievements within the American health delivery system. We predict that in general S 1391 will dramatically reduce the quality and scope of services rendered and, in particular, it will prohibit needed expansion and extension of services to many of the already underserved segments of our society. We have concluded that S 1391 would specifically penalize the sick, the poor, the terminally ill, the chronically ill, the aged -- those whom our members have particularly pledged themselves to serve.

Specific Objections

1) The Catholic Hospital Association must emphasize that a single component of the health care delivery system -- hospitals -- alone must not be burdened with payment control constraints as S 1391 proposes. Such a limited focus on hospitals, and hospitals only, is simplistic at best and insidious at worst. Rising health care costs are the result of a multitude of factors most of which are beyond the control of hospitals themselves. The rising expectations of the American people, in terms of quality, quantity and availability of health services, the inflationary push within the American economy, increased health benefits resulting from governmental programs and collective bargaining agreements and their impact on demand for limited health services and increased

expenses caused by ever increasing Federal and state regulations impacting on hospitals are just a few of the cost-push-demand pull factors that must be recognized in any analysis of health care costs in general and hospital costs in particular. To ignore such elements is naive and just not acceptable to those of us committed to the strengthening and improvement of the American health care delivery system.

2) We do not wish to imply that hospitals cannot influence certain health cost factors. Rising hospital care costs can be attributed generally to two basic factors: the increase in the cost per unit of service and the dramatic change in the mix, type, and scope of services rendered. Hospitals can be held accountable for the cost per unit of service. Congress and the American people have a right to demand an accounting of hospitals' efforts to increase productivity. S 1391, however, goes beyond the reasonable hospital controllable cost factors and assumes that hospitals alone are responsible for services which they simply cannot singificantly influence, let alone unilaterally control. Physicians admit patients; physicians order and direct the intensity, type and quantity of services rendered to each patient. Hospital managers cannot and should not unilaterally limit the introduction of new diagnostic testing procedures, surgical techniques, or more sophisticated methods of treatment which have contributed greatly to the prolongation of life, treatment of disease and the relief of human suffering. S 1391 focuses directly on the intensity and mix of patient services which rightly are the responsibility of the physician. The intent of the bill's designers is to put pressure on the hospital to control costs by limiting the hospital's revenue. To control costs in this manner

can only be obtained by curtailing the number, the quality, and the scope of services ordered by physicians for patients. The physician influence cannot be ignored and any attempt at curtailing services by constraining revenues without appreciating the ultimate consequences will, as previously mentioned, impact most directly on the sick-poor and the aged since they are less able to provide for themselves. The first to feel the impact of a squeeze on quality, scope and availability of hospital services are the very ones whose unmet health needs are the greatest and whose relative opportunities to receive needed services are least.

3) In the area of costs per service, S 1391 is inherently unjust. Hospitals purchase goods and services on the open market. Energy and food costs rise inexorably and are, for the most part, outside the control of hospital management. Hospitals cannot control drought, crop failures and the price of bread. Hospitals cannot control cost increases in linen, surgical instruments, furniture, malpractice insurance -- the list is endless. S 1391 singles out hospitals alone to somehow absorb these increases and hold their charges and thus their revenues to an articifically imposed limitation. The inequity in the short run -- indeed the impossibility over the long run -- is self evident.

4) S 1391 rewards less productive and higher cost institutions. By establishing both industry-wide and institutional inpatient revenue limitation based upon past experience, S 1391 penalizes those hospitals which have done the most to curb costs, to control utilization, to reduce their average lengths

of stay and those hospitals will be the first to feel the restaints of the proposed limitations. The more productive and low cost hospitals have little room for further economies. Economy must come at the expense of quality and scope of service. S 1391 is not an appropriate response to the demands of the American people for more and better health care services.

5) S 1391 fails to recognize the distinctions that exist between hospitals, even within a geographical region or a civic community. Be creating a single system of revenue restraints, the inner city hospital with its heavier patient load of the elderly, the sick-poor and the chronically ill and its frequently aging physical plant is lumped together with the new suburban hospital with its younger, more affluent patient population. The types of procedures performed and the tests and services required do vary dramatically. The impact of the single national limitation will bear most heavily on certain hospitals which are already facing the most difficult health service situations and which have the greatest demands being placed upon them. For example, those hospitals that have remained in the inner city where poor housing, high rates of unemployment, inadequate transportation already penetrate and make much more difficult the hospital's efforts to provide health care services will suffer first and most deeply as a result of the proposed economic controls. S 1391 ignores these basic "non health" yet human problems and treats the hospital and health care as if they operated and existed in a vacuum.

6) We believe and predict that in both the long and short run S 1391 will have a negative effect upon the quality of hospital services available to the American people. Short term economies of the type that will force the

hospital to place economics ahead of patients' needs in order to stay within the proposed revenue limit include: reductions in the quality and quantity of staff; reduction, if not elimination of educational programs; delayed building and equipment maintenance; denial of new and needed services and procedures; the alteration of service patterns by means of waiting lists for admissions; and the shift of responsibility for complicated, risky, or expensive treatments. In the long run, hospitals and physicians will encounter the wrath of the American people for the deterioration of a very significant element within the American health system -- the voluntary, community based hospital. The seeds of that deterioration process are S 1391. The distortions within the health care delivery system caused by the heavy-handed and short-sighted economic restrictions proposed in S 1391 will be very hard to correct.

CHA Recommendations

A) There must be a recognition in any "cost containment" legislation that the problem of rising costs cannot be laid on the doorstep of any one category of provider or any single component of the health care delivery system. Inflation affects all of us. Hospital costs cannot be contained by an arbitrary "freeze" on revenues. Equally important to the health industry is the very significant (and rightly so) increase in the public's expectation for health services. The fact that an increasing proportion of the Gross National Product being spent on health care for the American people is not per se undesirable. Our society has determined that "health" is a valuable goal to which it individually, collectively, and through government is willing to expend an increasing share of its resources.

B) Waste, duplication, and even mismanagement and fraud do exist. But Congress has and is addressing these problems in more appropriate and meaningful ways. We suggest that the full potential of the cost and quality control concepts endorsed in the Professional Standards Review Organization Act of 1972 (PSRO) have not been fully realized. We urge an acceleration of the implementation efforts for PSRO Programs consistent with needed changes in those parts of the Program that studies and testimonies have indicated require adjustment and/or elimination. To burden hospitals alone for cost control and utilization review can be attributed only to a lack of understanding of the history, experience and potential of PSRO Program as well as the role, function, and limitation of hospital administration. Again, physicians admit patients, order tests and services, and perform surgery. PSRO and its companion regulations properly address the problem in a comprehensive manner and with some qualifications offer the best methods for remedying utilization abuse and, thus increasing costs. S 1391 seeks to control utilization in the most heavy-handed way through controlling hospitals. S 1391 will not bring about desired utilization patterns. It ignores the very significant physician component. Such a simplistic approach will not work in the best interests of people generally and the sick person in particular.

C) Similarly, we support PL 93-641, the National Health Planning and Resources Development Act of 1974 -- particularly its certificate of need provisions. We encourage Congress to extend these requirements to the non-institutional components and to prevent the circumventing of the law by individual providers and other free-standing agencies. To concentrate only

on the hospital may be politically astute, but the health care of the American people is too important to be subject to political tradeoffs.

D) Last August, in testimony relative to the Medicare-Medicaid Reimbursement Reform Legislation, then pending, we endorsed the concept of prospective reimbursement. We repeat that recommendation. We incorporate by reference our earlier statement in its entirety.

Briefly:

a) We endorse the principle of prospective reimbursement adequate to meet the financial requirements of the individual hospital.

b) We propose the use of alternative systems of prospective reimbursement, thus recognizing the distinction between individual hospitals and the needs of the civic communities being served.

c) We call for the adoption of incentives and shared savings as part of the reimbursement mechanism.

E) While we deny that an emergency or "crisis" currently exists in the hospital field, we would encourage the early enactment of such a prospective system and full implementation at the earliest date.

F) We once again endorse and call for the adoption of Universal National Health Insurance. We know we will be able to work with this Congress and with the President in developing a program that will enable all of our people to receive the optimum of health care services efficiently, courteously, and without unreasonable costs.

CONCLUSION

The Catholic Hospital Association believes very strongly that the future success of the nation's health care delivery system depends very much on the continued strength and viability of its voluntary components and on the preservation of our nation's pluralistic health care delivery system. We foresee circumstances which may cause the private providers to be virtually forced out of existence. These alarming circumstances are aided and abetted for the most part by governmental over-regulation and bureaucratic red tape. HR 6575 is a prime example of complex controls and regulations with predictable destructive and counter-productive consequences for private health care providers. We caution against ill planned and ill-fated intrusions by government, at all levels, in the provision of health care services. We believe that Congress should make deliberate efforts to insure that the private, voluntary sector will survive and will in fact maintain its current proportionate role in the nation's health care delivery system.

ADVANCING VOLUNTARY LEADERSHIP IN A CHANGING WORLD

Chamber of Commerce of the United States
HILTON DAVIS, VICE PRESIDENT
LEGISLATIVE ACTION
202 · 659-6140
1615 H STREET, N.W.
WASHINGTON, D.C. 20062

July 26, 1977

The Honorable Edward M. Kennedy, Chairman
Subcommittee on Health and Scientific Research
Committee on Human Resources
United States Senate
Washington, D. C. 20510

Dear Mr. Chairman:

The Chamber of Commerce of the United States, which represents approximately 65,500 businesses, 2,550 state and local chambers and 1,150 trade and professional associations, shares the concern of the President and Congress that health care costs are in need of control. Our concern is based on the fact that the business community, through employment-related health plans, is the largest private purchaser of health services in the United States. Because of this large stake in the hospital and health industry, we feel that our position on methods to control health care costs is particularly relevant.

As your Subcommittee marks up S. 1391, the Senate version of H.R. 6575, we urge you to consider the views we expressed to the House Ways and Means Committee's Health Subcommittee on H.R. 6575 and to the Senate Finance Committee on S. 1470. Both statements are attached, but I will summarize them.

H.R. 6575 (S. 1391)

The National Chamber is opposed to H.R. 6575 because Title I is simply a form of temporary price controls which, historically, have been ineffective in controlling costs. In fact, in 1976, two years after Phase IV of the Economic Stabilization Act was lifted, health care costs rose by 30 percent.

Further, we oppose H.R. 6575 because Title II sets an arbitrary limit on capital spending, which does not accommodate differences among hospitals and would discourage needed investment that can reduce costs in the long term.

In effect, H.R. 6575 rewards inefficient, while penalizing efficient, hospitals. Moreover, the ceiling imposed by the Administration's plan could become the floor. This is undesirable since, in many states, existing measures to control costs are achieving levels at or just below H.R. 6575's objective.

S. 1470 (H.R. 7970)

The National Chamber essentially supports S. 1470's attempt to encourage prospective reimbursement practices between hospitals and payors. This approach offers a better incentive to control costs. However, the

bill should be broadened beyond Medicare and Medicaid to include all third party payors, so that public savings are not made at private sector expense.

The National Chamber also favors retaining the Health Insurance Benefits Advisory Council (HIBAC) so that public health policy will receive input from private industry. Recent evidence reveals the value of including management expertise in policies related to the health care industry. HIBAC (or a suitable replacement) should continue to give public health programs the benefit of such counsel.

* * * *

In sum, the National Chamber favors responsible attempts to control the rising cost of health care. Prospective reimbursement systems and better health planning (which allows local solutions to local problems) are two means of achieving this goal. Several other initiatives taken voluntarily by hospitals -- such as group purchasing, shared services, budget and rate review -- also demonstrate the ability to save money.

Transcending all of these positions and recommendations is the need to allow the private sector to develop methods of improving America's health care system. Supporting this view is the assessment of the Council on Wage and Price Stability. In its December 1976 report entitled, "The Complex Puzzle of Rising Health Care Costs: Can the Private Sector Fit It Together?", the Council stated:

> "Cost control incentives proposed by the private sector promise to be more effective than those imposed by the multitude of government agencies ... The private sector is motivated by economic incentives which the government will simply never share ... (These) incentive(s) ... (have) been the missing factor(s) in health care ... the key ingredient(s) in bringing about much needed change in the system ... In our opinion, the private sector is up to the challenge."

The National Chamber stands ready to assist your subcommittee in drafting legislation which will reduce costs while maintaining quality health services. Such a goal is attainable only by a system characterized by private initiatives.

Cordially,

Hilton Davis

Hilton Davis
Vice President
Legislative Action

Attachments

cc: Members, Subcommittee on Health and Scientific Research
Robert Wegner, Chief Majority Counsel
Spencer Johnson, Chief Minority Counsel

ADVANCING VOLUNTARY LEADERSHIP IN A CHANGING WORLD

Chamber of Commerce of the United States

LEGISLATIVE ACTION VICE PRESIDENT
HILTON DAVIS

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May 27, 1977

The Honorable Dan Rostenkowski, Chairman
Subcommittee on Health
Committee on Ways and Means
House of Representatives
Washington, D. C. 20515

COPY

Dear Mr. Chairman:

The Chamber of Commerce of the United States welcomes this opportunity to present its views on H.R. 6575, the "Hospital Cost Containment Act." Our membership of 64,000 business enterprises, 1100 trade and professional associations, and 2500 state and local chambers of commerce shares the deep concern of the Administration and the Congress over the rising cost of health care, including hospital services.

The purpose of the Administration's proposal is admirable, to bring increasing hospital costs more in line with the rest of the economy. However, we have serious reservations about the methods proposed to achieve this objective. Therefore, we oppose H.R. 6575.

Title I of H.R. 6575 places a transitional 9% ceiling on increases to inpatient charges by some 6,000 acute care and specialty hospitals. This title rests on a faulty premise -- that temporary price controls can control prices. In fact, short-term price controls have proved to be an ineffective solution to containing costs. For example, in 1976, two years after the last temporary controls -- Phase IV of the Economic Stabilization Act -- were lifted, health care costs rose by over 30%.

The rationale for price controls is further weakened in the bill, since certain types of hospitals and hospital workers are exempted from coverage. For example, federal hospitals are excluded from price controls; yet, hospitals operated by the Department of Defense are experiencing annual cost increases of approximately 14%, only slightly less than the national average. Also, the wages of non-supervisory personnel are exempt, but these workers comprise fully two-thirds of the hospital workforce. When salary increases are granted to this segment of employees, similar demands will surely be made by other hospital personnel. Thus, this title is at cross purposes with the intent of the bill.

Title II would place a national maximum of $2.5 billion on capital expenditures, based on a rigid state-population formula. Reduced to human terms, this means that approximately one dollar per month for every American citizen will be allowed for hospital improvement. However, some communities may need to spend more to provide adequate health services, while other areas with more established health programs may want to spend less. The bill does not accomodate these differences. Moreover, H.R. 6575 effectively usurps the authority of existing health planning laws such as state certificate of need and project review statutes. Thus, local decision-making is preempted by federal guidelines. We support strengthening the National Health Planning and Resources Development Act (P.L. 93-641), instead of enacting new legislation which undermines this existing program.

As another alternative, the Chamber supports some of the features of Senator Talmadge's "Medicare-Medicaid Administration and Reimbursement Act," S. 1470. This bill proposes prospective reimbursement as a method of controlling costs. It also provides for transitional allowances for hospitals which close or convert their acute care beds to accommodate other health care needs.

Finally, we support voluntary approaches to solving hospital cost increases. For instance, several states have enacted their own cost containment programs which have enabled them to contain increases at or below the level proposed by H.R. 6575. In some cases, these savings were the result of recommendations made by private industry through health systems agencies (HSAs). The Phoenix Experience in which business, HSAs and local hospitals cooperated to find local solutions to rising health costs is a prime example of successful voluntary action.

In sum, the Chamber opposes H.R. 6575 on the grounds that the proposal will be counterproductive to containing hospital costs. Price controls simply do not work and cause harm in the long run. Also, national limits on capital investment do not accommodate the unique needs of various communities. The goal of hospital cost containment is best served by improving P.L. 93-641 and encouraging private involvement in local health planning decisions.

As a supplement to this letter, we are attaching for your consideration the Chamber's recommendations for businessmen to attack the problem of soaring health care costs. These recommendations were originally presented to the Council on Wage and Price Stability last year. We feel they continue to have merit and should be considered in any plan which addresses this vital issue.

Also, the National Chamber has made its own financial commitment to controlling health costs, by supporting, through the Chamber Foundation, a comprehensive study to develop a national health care strategy, which will include recommendations on the containment of health care costs.

We would appreciate your consideration of our views, and we request that this statement be included in the hearing record.

Cordially,

Hilton Davis
Vice President
Legislative Action

Attachment

CC: Subcommittee Members
Chairman and Members of the Subcommittee on Health and Environment, Interstate and Foreign Commerce Committee
Paul G. Rettig, Majority Counsel
Harvey Pies, Minority Counsel

ATTACHMENT A

Source: "The Problem of Rising Health Care Costs"
Statement by the Chamber of Commerce of the United States
before the Council on Wage and Price Stability, by Roger
Sonnemann, Chairman, National Health Committee. October 28, 1976

Business Strategy for Health Care Cost Containment

First, the National Chamber and individual business leaders are encouraging participation by businessmen in health planning agencies being established as a result of the Health Planning and Resources Development Act of 1974. These agencies have the responsibility for developing a health plan for communities and reviewing proposed expenditures by health facilities for capital improvements. Any unnecessary projects would be denied.

Second, businessmen are encouraged to give enlightened service while serving on the boards of hospitals as hospitals trustees. Business must work with hospitals to develop cost-finding systems and hospital reimbursement formulas which provide incentives to hospitals to hold down costs. Prospective reimbursement, and other experimental payment mechanisms, should be implemented where feasible.

Local hospital overbedding results in unnecessary costs, either through overutilization of hospital services in an effort to keep the beds occupied or through the costs of carrying the empty beds. The problem of hospital overbedding can be controlled by hospital boards, planning agencies, Blue Cross Boards, and State "Certificate of Need" legislation.

Reimbursement formulas for services of hospital-based physicians (i.e. radiologists, pathologists) should assure that such services are not overutilized and unnecessary.

The building or purchasing of expensive but rarely-used facilities or equipment should be carefully controlled; i.e., brain scan equipment, cobalt therapy machines, and open heart surgery units should not proliferate to satisfy the "keep up with the Joneses" syndrome.

Effective utilization and peer review mechanisms should be developed to prevent unnecessary hospital usage. Hospitals in a given area should work toward increased use of shared facilities to avoid duplication of costs where possible.

Third, by working with Blue Cross, Blue Shield and insurance carriers, businessmen can investigate the type of initiatives that could control health costs. Individual benefit plan designs can be altered to deemphasize expensive hospital-based care and encourage the use of simple surgical procedures at outpatient surgical facilities, and preventive care measures.

Attachment A

Plan designs should incorporate simplified and effective co-insurance and deductibles to motivate consumers to buy care more prudently. Business can investigate and publicize the cost and service performance of local providers so consumers can make informed decisions. Presurgical screening and second medical opinions should be encouraged where possible and cost-effective. Employee benefit plans should be designed to control health costs with an emphasis on the reimbursement of health care providers, benefit utilization, eligibility and administration.

Fourth, Health Maintenance Organizations (HMO's) which represent another potential for reducing health care costs have been expanding as a result of Federal legislation that supports their development. Employers should promote the availability of alternate competitive types of health care delivery, such as HMOs. HMOs represent a major attempt to restructure the health delivery system. Unlike the fragmented fee-for-service system, HMO's provide both inpatient and ambulatory care within one organizational structure. The financial interdependence of physicians and hospitals eliminates the incentives for physicians to overprescribe more costly inpatient hospital services. Evidence exists that significant reductions in hospital utilization have been achieved as a direct result of HMO-type medical care management. Last year alone, the average premium for HMOs increased only half as fast as traditional insurance indemnity plans or Blue Cross and Blue Shield plans.

Fifth, businessmen can and should work toward the removal of restrictive state laws or regulations which limit the flexibility of providers or carriers in implementing new and innovative health care ideas. These include a host of subjects such as HMOs, medical professional liability insurance, certificate of need legislation, etc.











Statement of the

CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA

on: Medicare-Medicaid Administrative & Reimbursement Reform Act of 1977 (S. 1470)

to: Subcommittee on Health, Senate Finance Committee

by: Jan Peter Ozga

date: June 20, 1977

STATEMENT
on
MEDICARE - MEDICAID ADMINISTRATIVE AND
REIMBURSEMENT REFORM ACT OF 1977 (S. 1470)
for submission to the
SUBCOMMITTEE ON HEALTH
of the
SENATE FINANCE COMMITTEE
for the
CHAMBER OF COMMERCE OF THE UNITED STATES
by
Jan Peter Ozga*
June 20, 1977

The Chamber of Commerce of the United States welcomes this opportunity to present its views on S. 1470, the "Medicare-Medicaid Administrative and Reimbursement Reform Act of 1977." Our membership of more than 68,000 business firms, trade and professional associations, and local chambers of commerce shares with the Congress a deep concern over the rising cost of hospital and other health services, which are paid by Medicare and Medicaid as well as private health insurance plans.

In general, the National Chamber favors the approach to administrative and reimbursement reform contained in S. 1470. The bill represents a significant step in the right direction; and, with certain modifications, it could be an important factor in helping to solve some of our health care cost problems.

Before proceeding with our analysis of and positions on selected provisions of S. 1470, it might be helpful for committee members to learn about business' understanding of the health cost problem and employers' stake in this issue. After we have addressed S. 1470, we will include some examples of action taken by employers to help curb health costs, as well as some specific cost-savings activities in which the National Chamber is engaged.

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* Associate Director - Health Care, Economic Security, Education and Manpower Section, Chamber of Commerce of the United States

PROBLEM: HEALTH CARE COSTS

According to the Social Security Administration, last year nearly $140 billion was spent on personal health care services, over 40 percent of which went toward hospital bills. The average hospital stay now costs $1,300, up a whopping 1,000 percent since 1950 compared to a 236 percent increase in consumer prices as a whole. The Council on Wage and Price Stability reports that the two largest increases over the past quarter century occurred between 1976-71, after the implementation of Medicare and Medicaid, and between 1974 and 1975, soon after the Economic Stabilization program (during 1971-1974) ended. These figures underscore the inflationary effect which governmental programs and price controls have had on health care.

Last year more than $33 billion was spent on Medicare and Medicaid, far exceeding the original estimates when these public health programs were enacted over a decade ago. Of this amount, $25 billion -- over 75 percent -- was for claims covering hospital charges.

Over 90 percent of all hospital charges are paid by someone other than the patient, usually through public or private insurance programs. It is no wonder then that very few persons feel the full impact of rising health care costs -- increasing at an annual rate of 15 percent -- and that attempts to educate consumers to make more cost-saving decisions regarding their health care have not been successful.

There are a number of reasons for escalating health care costs. These include: overall inflation; the cost of complying with governmental regulations; the growth of our population, coupled with expanded health care benefits and increased demand for services; malpractice awards and protection (and related factors such as over-prescribing and overtesting); and heavy investment in new technology. However, accelerating the rise of health care costs are the expense of public health programs such as Medicare and Medicaid and a 30% rise in such costs within two years when Phase IV of the wage and price controls were lifted from the health care industry in 1974.

BUSINESS ROLE IN HEALTH CARE

The cost of current health-related benefits to business is 25 times higher than it was a quarter of a century ago. Whereas in 1950, less than half of all wage and salary earners had hospitalization, surgical and regular medical coverage, the vast majority of workers now have such coverage.

Between 1965 and 1976, while wages rose about 85 percent, health-related benefit costs increased over 200 percent. According to the Rand Corporation, approximately 80 percent of some $33 billion in private health insurance premiums are paid through employment related plans, with employers paying an average of two-thirds of these costs, making business' the largest purchaser of health care services.

These rising health care costs have caused some health experts to advocate extensive government controls of the health care industry. The National Chamber disagrees with this approach and recommends instead an approach along the lines indicated in a recent assessment by Clark C. Havighurst, Professor of Law, Duke University. Prof. Havighurst, in discussing the role of competition in cost containment, stated that he would still "value the market mechanism highly and allow it a prominent part, not only because it can contain costs and force the system to give value for money, but also because it preserves consumers' and providers' opportunity to express their other values and preferences ..."

The Chamber's specific policy on "Efficiency and Control of Costs," which was adopted through a referendum of our organization members, follows:

Efficiency and Control of Costs

Business should encourage:

1. All hospitals, extended care and nursing home facilities to adopt uniform accounting practices, financial reporting and cost-finding systems;
2. All hospitals to establish arrangements to review and monitor (peer review) the appropriateness of such items as hospital admissions, duration of stay, and treatment prescribed;
3. All hospitals, extended care and nursing home facilities to accept reimbursement for services on a prospective, rather than on an retroactive ("cost-plus") basis, with budgets, financial statements, statistics and services to be reviewed by private and public payers;
4. Physicians to accept reimbursement for "usual and customary charges" as payment in full for services rendered;
5. Each hospital to charge the same prices for the same services, regardless of the kind of benefit protection of the patient;
6. The provision of effective peer and utilization review of all inpatient and outpatient health services.

Employee benefit programs should:

1. Be broadened to encourage health care in the least expensive manner; and
2. Require deductibles and co-payment for services received, where feasible.

THE TALMADGE BILL (S. 1470)

S. 1470, the "Medicare and Medicaid Reimbursement and Administrative Reform Act of 1977," represents a significant step in the right direction to help curb rising health care costs. The bill envisions instituting reform in the practices of hospitals, physicians, nursing homes, and in the administration of Medicare and Medicaid and related public health programs.

Hospital Reform

The National Chamber supports in general S. 1470's cost-saving concept of establishing prospective limits on reimbursable per diem operating costs. This approach should help provide necessary incentives to hospitals to become more cost-efficient.

This concept of reform is good, necessary, and valid: a textbook ideal approach. A realistic approach would outline a broad plan rather than set out specific solutions as this bill attempts in certain areas. The bill's most basic flaw is that it is the crude beginning of a federally centralized rate setting system. Serious questions arise as to whether rate setting, with all its constraints on health care delivery resources will curb spiralling health care costs, correct fraud and abuse of the Medicare/Medicaid program and have an overall positive effect on the health care system.

Although S. 1470's incentive reimbursement system is a better method of controlling costs than the price ceiling on inpatient charges proposed by the Administration's "Hospital Cost Containment Act," we cannot entirely endorse this provision since as drafted it does not effectively include all third-party payors. Public health cost-savings should not be made at private expense. In earlier testimony before the Congress, for example, a hospital association has admitted that losses in revenue resulting from public reimbursement policy are compensated by increasing charges to private payors, such as Blue Cross, commercial insurers or patients.

When introducing S. 1470, Senator Talmadge stated that he was "quite open to the idea" of broadening his proposal to reach beyond Medicare and Medicaid. This bill appears to reflect his intentions, with provisions such as "the (reimbursement) system applies to all revenue sources for hospitals within the State;" and, further, hospitals must "not agree to increase amounts due from any individual organization or agency in order to offset reductions," resulting from Medicare and Medicaid reimbursement policies. However, S. 1470 does not define how such a discriminatory transfer of costs will be averted.

Therefore, the National Chamber recommends that S. 1470 be expanded to include both public and private third party payors, so that public savings will not be made at private sector expense.

The National Chamber also supports S. 1470's provision for uniform accounting among hospitals to help provide a basis for cost-saving actions. However, because of the diversity among hospitals and other health care facilities, we recommend that this reform bill also include uniform financial reporting and standardized cost-finding systems, with sufficient flexibility to accommodate different management practices.

Another area of cost-savings which S. 1470 does not address, but which the National Chamber finds worthy of serious consideration, is energy savings. It has been estimated that hospitals and nursing homes could save as much as 20 percent on the cost of energy without using capital investment funds just by initiating more efficient energy practices. Using capital investments to purchase energy saving devices, energy savings could be as high as 40 percent.

Another cost-saving technique which has shown evidence of success is budget or rate review, as now practiced in several states. Such states -- one of which initiated this system on a voluntary basis -- are exhibiting cost-savings which equal or exceed the objectives set by S. 1470 and other related legislation. Clearly, rate review is another cost containment option which should be included in S. 1470. In fact, 20 percent of all hospitals with similar programs are holding cost increases to nine percent or less.

The National Chamber also supports S. 1470's attempts to control capital expenditures by extending and expanding the authority of health planning statutes. These include responsible decisions made by project review under Section 1122 of P.L. 92-603 and Section 1526 under P.L. 93-641, as well as State Certificates of Need. We also favor the principle that decisions on capital expenditures in metropolitan areas which cross state lines should include input from states in which the metro area is located. Projects which are disallowed by local and state health planning authorities should not receive Medicare or Medicaid reimbursement for costs associated with rejected projects.

Finally, the National Chamber urges the Committee to consider recommendations made by certain health provider and insurer groups advocating inclusion of other cost-savings innovations in S. 1470. These include incentives for group purchasing, shared services, consumer education, peer and utilization review (including second opinions on surgery decisions), and health care economic courses in medical schools and hospitals. Generally, attempts should be made to study institutions which have implemented one or more of these cost-saving procedures and to determine if they should be utilized more widely.

Administrative Reform

Among the major administrative reforms in S. 1470 is the creation of the Health Care Financing Administration, which consolidates into one agency four related public health programs: Medicare, Medicaid, Office of Long-Term Care, and Bureau of Quality Assurance.

The National Chamber recognizes the need for better coordination and administration of these public health programs. Although HCFA has already been created through administrative action taken by the Secretary of Health, Education, and Welfare, we share Senator Talmadge's concern that this new agency should not increase the bureaucracy. However, we fail to see how S. 1470 will prevent this.

S. 1470 advocates the abolition of the Health Insurance Benefits Advisory Council (HIBAC). We oppose this provision. HIBAC enables valuable private sector opinion -- including high level management expertise -- to become part of public policy. Eliminating this advisory body would remove an important dimension in helping to administer Medicare and Medicaid. If S. 1470 is expanded to include all insurers, the retention of HIBAC becomes even more essential to the concept of public-private collaboration. Therefore, S. 1470 should retain HIBAC or at least replace this body with a suitable counterpart.

Finally, the National Chamber supports S. 1470's provision to reduce or eliminate fraud and abuse in public health programs. These include S. 1470's provision that claims will be denied to persons falsifying Medicaid eligibility by transfering temporarily their property to relatives or friends.

BUSINESS ROLE IN CONTROLLING COSTS

Recognizing that controlling health care costs should not be a unilateral effort, but rather a partnership of private and public endeavors, the business community has been expanding its role in helping to curb rising health care costs. Among a number of examples which could be cited are:

• "The Phoenix Experience," in which a prominent manufacturer in the Phoenix area collaborated with several hospitals to help keep their costs down. This collaboration was facilitated by the local health planning agency, which acted as an intermediary in helping to identify specific high cost areas within these hospitals. The result of this collaboration was a number of recommendations, which, when implemented, led to an immediate reduction in hospital costs and improved communication among the hospitals.

• In Akron, Ohio businessmen serving on health project review teams were instrumental in saving nearly $80 million by disallowing several unnecessary hospital projects.

• Business works in other ways to reduce health care costs through the provision of preventive health services. A survey recently conducted by a major tire manufacturer of some 80 companies, with from 5,000 to 100,000 employees, revealed that the following services were offered:

SERVICES OFFERED	PERCENT OF COMPANIES OFFERING SERVICE
• Pre-placement Physical Examination	96%
• Environmental Health Examination	75%
• Promotion Examination	33%
• Overseas Examination	77%
• Management Physical Examination	82%
• Medical Counseling	82%
• Treatment of Occupational Conditions	91%
• Limited Treatment of Non-Occupational Conditions	87%
• Physical Conditioning for Management	26%

o The National Chamber Foundation is embarking on a study to develop a "National Health Care Strategy." A paramount feature of this study will be recommendations for controlling health care costs that can be utilized by business firms in any community.

o Finally, the National Chamber presented a strategy to the Council on Wage and Price Stability last year that businessmen could enact to contain health care costs in advance of legislatively created programs. This strategy is contained in Attachment A.

CONCLUSION

The National Chamber supports S. 1470 as a significant step in the right direction toward controlling health care costs. The bill's administrative and reimbursement reforms appear to offer incentives to the health care industry to become more cost-efficient and effective. However, we favor broadening the coverage of S. 1470 to include both private and public third party payors, so that public savings will not be made at private sector expense. Also, we support the retention of the Health Insurance Benefits Advisory Council, to enable private sector opinion to become part of public health policy.

In sum, the National Chamber holds that cost-saving proposals should encourage competition and provide well-designed incentives which allow the nation's health industry to operate at its optimum. We further recommend flexibility to allow for innovation, so that our health care system can better serve the American people.

Attachment A

BUSINESS STRATEGY FOR HEALTH CARE COST CONTAINMENT

(Source: Excerpted from "The Problem of Rising Health Care Costs," a statement by the Chamber of Commerce of the United States before the Council on Wage and Price Stability, October 28, 1976.)

First, the National Chamber and individual business leaders are encouraging participation by businessmen in health planning agencies being established as a result of the Health Planning and Resources Development Act of 1974. These agencies have the responsibility for developing a health plan for communities and reviewing proposed expenditures by health facilities for capital improvements. Any unnecessary projects would be denied.

Second, businessmen are encouraged to give enlightened service while serving on the boards of hospitals as hospitals trustees. Business must work with hospitals to develop cost-finding systems and hospital reimbursement formulas which provide incentives to hospitals to hold down costs. Prospective reimbursement, and other experimental payment mechanisms should be implemented where feasible.

Local hospital overbedding results in unnecessary costs, either through overutilization of hospital services in an effort to keep the beds occupied or through the costs of carrying the empty beds. The problem of hospital overbedding can be controlled by hospital boards, planning agencies, Blue Cross Boards, and State "Certificate of Need" legislation.

Reimbursement formulas for services of hospital-based physicians (i.e. radiologists, pathologists) should assure that such services are not overutilized and unnecessary.

The building or purchasing of expensive but rarely-used facilities or equipment should be carefully controlled; i.e., brain scan equipment, cobalt therapy machines, and open heart surgery units should not proliferate to satisfy the "keep up with the Joneses" syndrome.

Effective utilization and peer review mechanisms should be developed to prevent unnecessary hospital usage. Hospitals in a given area should work toward increased use of shared facilities to avoid duplication of costs where possible.

Third, by working with Blue Cross, Blue Shield and insurance carriers, businessmen can investigate the type of initiatives that could control health costs. Individual benefit plan designs can be altered to deemphasize expensive hospital-based care and encourage the use of simple surgical procedures at outpatient surgical facilities, and preventive care measures.

Plan designs should incorporate simplified and effective co-insurance and deductibles to motivate consumers to buy care more prudently. Business can investigate and publicize the cost and service performance of local providers so consumers can make informed decisions. Presurgical screening and second medical opinions should be encouraged where possible and cost-effective. Employee benefit plans should be designed to control health costs with an emphasis on the reimbursement of health care providers, benefit utilization, eligibility and administration.

Fourth, Health Maintenance Organizations (HMO's) which represent another potential for reducing health care costs have been expanding as a result of Federal legislation that supports their development. Employers should promote the availability of alternate competitive types of health care delivery, such as HMOs. HMOs represent a major attempt to restructure the health delivery system. Unlike the fragmented fee-for-service system, HMO's provide both inpatient and ambulatory care within one organizational structure. The financial interdependence of physicians and hospitals eliminates the incentives for physicians to overprescribe more costly inpatient hospital services. Evidence exists that significant reductions in hospital utilization have been achieved as a direct result of HMO-type medical care management. Last year alone, the average premium for HMOs increased only half as fast as traditional insurance indemnity plans or Blue Cross and Blue Shield plans.

Fifth, businessmen can and should work toward the removal of restrictive state laws or regulations which limit the flexibility of providers or carriers in implementing new and innovative health care ideas. These include a host of subjects such as HMOs, medical professional liability insurance, certificate of need legislation, etc.

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President
Evangelical Hospital Association

June 21, 1977

Honorable Edward M. Kennedy
Room 431
Old Senate Office Bldg.
Washington, D. C. 20510

Honorable Herman E. Talmadge
Room 109
Old Senate Office Bldg.
Washington, D. C. 20510

Dear Senators Kennedy and Talmadge

Enclosed are five copies of the Chicago Hospital Council's written testimony on S.1391, "The Hospital Cost Control Act of 1977". We would appreciate your arranging for our testimony to become part of the official record, on the hearing on the bill and hope that you will also share copies with the members of the Subcommittee on Health and Scientific Research of the Committee on Human Resources and the Sub-committee on Health of the Committee on Finance.

Please let me know if you wish additional information.

Sincerely yours,

Howard F. Cook
President

jr

enc

cc: Senator Charles H. Percy
Senator Adlai E. Stevenson III

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CHICAGO HOSPITAL COUNCIL
840 NORTH LAKE SHORE DRIVE • CHICAGO 60611
751-0700

Written Testimony on the "Hospital Cost Control Act of 1977" (S1391)

Presented To:

The Subcommittee on Health and
Scientific Research of the
Committee on Human Resources

and

The Subcommittee on Health of
the Committee on Finance

United States Senate

Submitted by:

Howard F. Cook
President
Chicago Hospital Council

June 21, 1977

CHICAGO HOSPITAL COUNCIL
840 NORTH LAKE SHORE DRIVE • CHICAGO 60611
751-0700

I am Howard F. Cook, president of the Chicago Hospital Council. The Chicago Hospital Council was established in 1935. Our membership now includes 100 metropolitan Chicago hospitals. The Council's primary purpose is to help our member hospitals meet the public's needs for hospital facilities and services.

The Chicago Hospital Council strongly opposes "The Hospital Cost Control Act of 1977" (S1391) for the following reasons:

1. The legislation limits hospital revenues while doing nothing to control significantly rising costs hospitals incur in providing patient care.
2. The bill ignores the numerous controls which have been effected by federal and state governments in recent years.
3. The proposed legislation improperly assumes that hospitals are generally wasteful and inefficient.
4. We must seriously question the federal government's ability to properly administer the program.

<u>The Legislation Limits Hospital Revenues While Doing Nothing To Control Significantly Rising Costs Hospitals Incur In Providing Patient Care</u>

The reasons for hospital cost increases are many and complex. However, S1391 does nothing to identify and correct those reasons. As a result, hospital expenses would soon exceed revenues, meaning financial disaster for hospitals. The only

other alternatives would be significantly reduced availability and quality of hospital services.

Hospitals, like other industries, purchase goods and services in the general marketplace. However, the general inflation rate does not properly explain hospitals' increased costs for goods and services purchased in the gneral marketplace. That is because many of the goods and services hopsitals purchase have increased at rates substantially higher than the general inflation rate. For example, malpractice insurance premiums for Chicago-area hospitals increased 1,247% between 1971 and 1976. As a result, malpractice insurance which had cost $0.74 per patient day in 1971, cost $8.79 per patient day in 1976.

Yet, only about 53% of the increased cost of hospital care is attributable to increases in the costs of goods and services hospitals purchase. The remainder is due to the increased intensity of service. That is, the hospitalized patient today receives more services per day and per stay than was true several years ago. This is partly because many of the services provided today weren't even available five or ten years ago. It is also due to other factors including an older population, and a change in the type of patient hospitalized (e.g. patients are no longer hospitalized for croup). These intensity changes are almost exclusively beyond the hospital's control. Many of the new services (radiation therapy, open heart surgery, kidney transplantation, etc.) mean people are alive and productive today

who, not many years ago, would have died or would have lived as invlaids.

One example of the effect of changing intensity is the increase in laboratory tests. In metropolitan Chicago, the average hospital in-patient received 94% more laboratory tests in 1976 than he had in 1969.

Government and quasi-government regulation itself has increased hospital costs. One large Chicago hospital reports that meeting newly changed life safety codes will cost it $12 million. The facility must meet those standards to continue participation in Medicare and Medicaid. Further, concurrent stay review now required by Medicare and Medicaid utilization review regulations and the Professional Standards Review Organization Program costs a conservatively estimated $10 per patient stay. While length of stay has been declining, that trend was evident before these programs were implemented; and there has been no conclusive proof that they are effective. These are but two of many examples of government caused cost increases.

Clearly, S1391 will do nothing to deal with these and the many other complex reasons for hospital cost increases. While hospitals, like any industry (including government) can always squeeze out some additional savings, the net result would have to be the reduced availability and quality of care. While the public, hospitals, and government must all be concerned about the high cost of health care, there is no indication that the public is willing

to accept the reduced availability or quality of care that would result from passage of S1391.

With S1391 controlling revenues, but not costs, the fiscal impact upon Chicago-area hospitals would be disastrous. Between 1977 and 1980 we project hospital costs would exceed allowable revenues by roughly $560 million. The excess of costs over revenues would hit $293 million in 1980 alone. Thus, by 1980, Chicago-area hospitals will be paid about 90% of their total costs. That would be catastrophic with respect to cash flow, and it would have to mean a reduction in availability and quality of service. It would also mean a halt to developing new and improved services.

The Bill Ignores the Numerous Controls Which Have Been Effected by Federal and State Governments in Recent Years. The bill ignores that in recent years government, at both the federal and state levels, has instituted numerous cost-containment measures. Those include Medicare and Medicaid utilization review regulations, the Professional Standards Review Organization Program, Health Systems Agencies, Medicare and Medicaid reimbursement ceilings, and, in Illinois, as in many other states, certificate of need legislation. These programs are all relatively new, and they have not been in place long enough to properly assess their impact.

Further, the federal government does not appear to have established effective mechanisms for evaluating the impact

of these recently established controls. Superimposing additional controls will result in confusion, duplication of regulatory activities, and no evaluation of which regulatory mechanisms, if any, are effective in contolling cost increases.

Those countries which have embarked upon the equivalency of complete regulation tnrough government operation of health care facilities have experienced exactly the same result as we have in the United States -- uncontrollable hospital costs. Thus, we must carefully test and evaluate the various control mechanisms which are being proposed to insure that they are cost-effective and not dangerous to our nation's health.

S1391 asks the nation's hospitals to achieve a goal that the federal government apparently has not been able to achieve itself. We looked at the cost increases for the three short-term Veterans Administration hospitals in metropolitan Chicago for the years 1974-1975. The data were from the American Hospital Association's "Guide to the Health Care Field" published in 1975 and 1976. The cost increases for the three hospitals averaged 17.1% per patient day, and total expenses increased an average of 13.1%. These average increases are significantly greater than the roughly 9% cap contained in S1391.

Our presentation of these figures is not meant to cast the Chicago-area Veterans Hospitals in a bad light. They are excellent hospitals. However, the figures for those hospitals clearly

illustrate how unrealistic S1391 is.

The Proposed Legislation Improperly Assumes that Hospitals are Generally Wasteful and Inefficient.

We often hear that hospitals lack incentives to contain costs. Yet, when one looks objectively one sees that hospitals have voluntarily attempted to contain costs and have an excellent list of achievements in this regard. Some Chicago-area examples indicate this very clearly.

As long ago as 1961 Chicago-area hospitals were among the first in the country to support utilization review. The Chicago Hospital Council, together with the Chicago Medical Society, Chicago Blue Cross, the Chicago Federation of Labor, and the Chicago Association of Commerce and Industry, developed and issued a statement urging hospitals and doctors to establish committees to evaluate utilization. The statement also urged individual members of the public to "use but not abuse" hospital insurance, and employers to provide hospital insurance coverage with utilization controls. The Chicago Hospital Council continued by assisting our member hospitals in such efforts. For these and other reasons, length of stay declined in the 1960's and 1970's, well before government programs took hold. This decline in length of stay is even more commendable when we remember that the number and proportion of aged persons increased during the same period of time.

Chicago-area hospitals' support of hospital planning goes back to the 1950's, when the Council was supportive of the Hospital Planning Council of Metropolitan Chicago. That support for planning has continued over the years, and we have encouraged our member hospitals to plan jointly and have assisted the comprehensive health planning agencies and, today, the Health Systems Agencies in their work.

The Council developed a "Workbook on Short-Term Planning" to aid hospitals in carrying out their own planning efforts. In addition, the Council has provided assistance to hospitals in completing the Workbook, or in carrying out other planning activities. The Workbook has been recognized by federal and state health care planning officials, and over 75% of our member hospitals have completed it.

Metropolitan Chicago hospitals save over $10 million a year through the Chicago Hospital Council's shared services programs. These programs are among the most mature in the nation and began developing in 1963. At that time, the Council developed a management consulting program. In 1965, the Council established a group purchasing program. Member hospitals purchased $55 million worth of goods and services through the program in 1976 achieving savings of approximately $6 million per year via the one service alone. In 1972, Chicago-area hospitals opened two shared laundry plans. They now provide complete linen and

laundry service for 20 hospitals aggregating 7,700 hospital beds. Productivity of laundry workers employed in those facilities is over twice as high as the productivity of workers in the laundries replaced by the new facilities. In 1975 the Council began an unemployment compensation administration program which contests nonvalid claims and helps hospitals avoid avoidable unemployment compensation claims. The 65 participating hospitals are saving approximately $2 million a year through that program.

One often hears about the existence of unnecessary obstetrical units. Yet, over the years the number of obstetrical units in metropolitan Chicago has declined by 20%. In 1963, there were 98 such units. There were 79 in 1976.

Further, growth in hospital beds in metropolitan Chicago has been generally consistent with growth in population and growth in admission rates. This would indicate that our work in area-wide and institutional planning has been successful to a considerable extent. For example, in 1965-70, the population in metropolitan Chicago grew by 4.3%. Due to the time needed to contruct new hospital facilities, we must look at the growth in the number of beds occurring about five years after a population change. Growth in the number of beds was 5.4% for the period 1970-1975, a figure very close to the population growth figure. During the period 1970-1975, hospital admissions grew by 11.6% in metropolitan Chicago, more than twice the growth rate for beds.

Reduction in the number of beds to that called for in S1391 would mean about 170,000 patients (about 17%) per year now accommodated in Chicago-area hospitals could not be admitted. Crowding would be such that the ability to hospitalize routine emergency patients and those injured in major disasters would be severly limited during many days of the year.

The proposed ceiling on capital expenditures will clearly mean a decline in availability of services and problems associated with inability to modernize or replace antiquated facilities. Assuming the capital expendiure allotment would be distributed based on population, about $83 million in capital expenditures per year would be allowed in metropolitan Chicago. Yet, Chicago-area hospitals have been granted certificates of need amounting to about $250 million per year for capital items. Further, many of the beds located in inner city areas are extremely antiquated and in need of replacement. However, the capital expenditures limit would make needed replacement and upgrading of facilities to meet current standards impossible.

Chicago-area hospitals have demonstrated their responsiblity to contain costs in numerous ways. S1391 ignores such efforts and would actually penalize those that have been most efficient.

<u>We Must Seriously Question the Federal Government's Ability to Properly Implement the Program</u>

The federal government has demonstrated its inability to implement major programs in a timely and effective manner. For example, PL92-603, the legislation authorizing establishment of Professional Standards Review Organizations, was approved in October, 1972. Only now is the program being implemented in the Chicago-area's Cook County, with complete implementation not likely until the end of the year. Most of the rest of metropolitan Chicago does not even have a PSRO in the development state.

As another example, Public Law 93-641 was signed into law in Janaury, 1975. That law called for establishment of Health Systems Agencies which were not very dissimilar from the comprehensive health planning (b) agencies in place since passage of Public Law 89-749 in 1966. Yet, over two years after passage of PL93-641, the Health Systems Agencies are still in their infancy and do not have completed plans with which to do their work.

General Comments

I have touched upon just a few of the many reasons why S1391 would be inequitable and a mistake. America has an excellent health care and hospital system, and S1391 would be a significant step toward destroying that system. We do need to take steps to attempt to contain increased health care costs. Hospitals in Chicago are anxious to work with

government, industry, and the public in doing so, and they have been attempting to contain costs for many years. However, S1391 does not pose that type of opportunity.

I hope our comments have been helpful. We would be pleased to provide additional information.



Working For Your Health

The Colorado Hospital Association
Position on Hospital Cost Containment Act of 1977
H.R. - 6575 and S. - 1391

The Colorado Hospital Association officially takes a position in opposition to the passage of H.R. 6575 and S. 1391. It is the considered judgement of the Board of Trustees of the Colorado Hospital Association that H.R. 6575 and S. 1391 is an inappropriate and inequitable concept and that:

1. This legislation is unfair. It is placing a limitation on one segment of the economy that is required to respond to all the other sectors of the economy that are not controlled by paying increased prices for costs of goods and services.

    1) Colorado: Malpractice example: 1976 premium of 85,000; 1977 premium $190,000 plus dropped coverage of nurse anesthetists. Petroleum-based products up 200% in less than 5 years--utilities costs up 70%.

2. The concept incorporated in this Bill is unsound since it must relate to a variety of institutions and a variety of services and, therefore, it is not possible to adequately and equitably place an arbitrary limit on the entire industry. Such limits would penalize more stringently the efficient hospitals without creating financial incentives and possibly would undermine the financial solvency of such hospitals.

    2) Colorado: See #9

3. Little or no recognition is made for the controls that are already in place, such as, Certificate of Need, PSRO, Shared Services, Mergers, and a variety of other new services which are directed toward cost containment. Many of these programs have been in effect for only a short period of time and have not had an opportunity to demonstrate any substantial degree of reduction in the rate of increases.

    3) Colorado: A State Certificate of Need has been in place since 1973--PSRO has lowered the length of stay to 5.7--Shared Service example: Purchasing savings $2.8 million 1976--individual hospital cost containment programs.

Colorado Hospital Association, 2140 South Holly, Denver, Colorado 80222 (303) 758-1630

4. The legislation proposed is complex with new definitions and formulas which have not been tested. It will be difficult to police and will require penalties on the hospitals when they will not be aware of the penalties applied until after the fact. Another case of government irresponsibility by retrospective penalty.

   4) Colorado: Colorado hospitals are already experiencing retrospective penalties with the Medicaid Program. Further retrospective penalties will jeopardize the financial stability of the hospital.

5. The patient, the real victim, will be the one to suffer most from this piece of legislation in that it will take away from the local level, recognition of services that are offered. An obvious result will be an overall reduction in services without recognition of local need and special circumstances.

   5) Colorado: Service in hospitals throughout the State vary from the most sophisticated, tertiary care to the very basic hospital care rendered by a small hospital. A difference of this magnitude requires local consideration.

6. Application of a limit does not give sufficient recognition above the CPI to allow for the high priced market basket of the hospital.

   6) See #1

7. The Legislation does not provide for a state to obtain waiver if that state established a Rate Review mechanism.

   7) Colorado: A bill containing Rate Review authority has passed the House in Colorado and is now being heard in the Senate. Knowledgeable people have proclaimed it to be the model of all rate regulation legislative efforts.

8. Capital dollars would be distributed on the basis of a population formula rather than on a demonstrated need. This will continue to emphasize construction in areas that may not have a need---inequitable and unfair in establishing the base year for limitation on hospital capital expenditure.

9. A National ceiling on beds and a standard for occupancy is totally unrealistic considering the differences in population, geographics, etc.

   9) Colorado: Hospital sizes range from 12 bed units

to over 600 beds. Mountainous terrains and sparsely populated areas to heavily populated metro area--one standard simply cannot apply and recognize the characteristics and needs of the community.

It is our position that the State should be delegated the responsibility for cost containment in the health care field and if the Federal Government has a role to play, it would be to establish guidelines for the states. There are other alternatives to this program, some of which are listed below:

1. Delegation to the State for Rate Review to be applied to all payers. Medicare and Medicaid share in the responsibilities to participate, as well as private carriers on an equal share basis.

2. Each state to work with their congressional delegation regarding the overregulation in the health care field and its impact on rising cost. A Cost Containment Program ignored in H.R. 6575 and S. 1391.

3. To conduct in cooperation with Congress an investigation into the causes for the increased cost of supplies and equipment to the health care industry.

4. To revamp the third party payment mechanism system, including government and private pay to reduce inequities, to build copayments and deductibles so that the demand by the citizens will be reflecting their responsibility and share in the cost.

5. To recognize in any payment system, case mix and intensity of services.

6. To establish a health policy group of Congressional Representatives and State Representatives to provide input into the National Health Care Policy.

7. Through a Rate Review Program, establish a uniform accounting and statistical reporting system; a pricing structure to bring about a more uniform type of payment and a more comparable and competitive way of pricing those services.

8. To institute on a voluntary basis a state disclosure program.

Colorado Hospital Association and its member hospitals urge the defeat of H.R. 6575 and S. 1391 for the above reasons.

Colorado Hospital Association, 2140 South Holly, Denver, Colorado 80222 (303) 758-1630

TELEPHONE: 618/635-2200

COMMUNITY MEMORIAL HOSPITAL

STAUNTON, ILLINOIS 62088

May 23, 1977

William M. Reger, III
Executive Director

Donald W. Brunnworth
Associate Director

Honorable Edward Kennedy
United States Senate
Washington, D.C. 20510

Dear Sir:

We are responding to the recent Hospital Cost Containment (H.R. 6575/S. 1391) proposal made by President Carter. We feel that President Carter is saying to rural America that it cannot have the same quality of health care the cities have. This proposal made by President Carter will lead the United States to the kind of health care system found in Sweden. This system will mean that our citizens will be directed to major Medical Centers which handle or care for patients who have a particular kind of diagnosis such as Heart Disease. It may mean that the patient will be far from his home and that his relatives will not always have the means to visit them. Low morale and poor recuperation of these patients will be a surety.

We suggest that Congress, in considering President Carter's Hospital Cost Containment Act of 1977, first define the quality of health all Americans should have, both in the city and rural America. We bring to your attention the Preamble of the Constitution of the World Health Association which has defined quality of health and we quote, "Health means more than freedom from disease, freedom from pain, freedom from untimely death. It means optimum physical, mental, and social efficiency and well being." It is our opinion that health under this definition is unattainable. We think a definition for the quality of health should not be so ideal. The World Health Association's definition will definitely increase the cost of health care.

We feel that any fixed ceiling on hospital reimbursement, without controls on the wages of hospital employees and the price of supplies and services purchases by hospitals will lead the nation's hospital industry to bankruptcy. This is plain common sense. We can control our internal costs because we control all factors involved, but we cannot control external influences imposed upon us as hospitals. For example:

1. Malpractice insurance - At our facility increased 300% between 1974 and

95-105 O - 77 - pt. 2 - 19

1977 with a reduction in the amount of coverage incurred and changing insurance companies to obtain the lowest price, which any prudent buyer would have done.

2. Workman's Compensation - Illinois State law has increased the cost of Workman's Compensation for our facility 40% between 1976 and 1977.

3. Federal minimum wage - Congressional action has increased the cost of our employee wages 45% between 1974 and 1975.

4. Service Contracts:

   A. X-ray equipment service agreement increased 25% between 1976 and 1977.

   B. Coronary Care equipment service agreement increased 25% between 1976 and 1977.

   C. It should be noted that since we are located in a rural area our service agreements are higher than those in metropolation areas. We are limited to dealing with the manufacturer of our equipment because others will not service equipment they do not manufacture.

5. Hospital Codes:

   A. We are incensed over the Honorable Mr. Califano's statement on the 'Today Show' concerning his example that in the past year hospitals could have saved $332,000,000, if "they had been a little more careful in their use of energy". This truly indicates he may not be in the real world of hospitals and health care. Yes, we could save another 30% in our energy costs if we could violate hospital codes. These codes have been established by State and Federal regulations and cannot be violated. Place the blame where it belongs, on the codes, not the hospitals.

   B. Another example of codes - The Joint Commission on Accreditation of Hospitals requires that we, as hospitals, inspect all appliances brought into our facility by our patients, (radios, hair dryers, razors, etc...). Question one; 'how many individuals are injured or die from electrocution of these appliances within the hospital atmosphere?' If no one is injured or dies, and to date we have not read or heard of such an incident, then this code is ridiculous.

   C. We suggest all codes imposed upon hospitals be re-analyzed. Cost benefit analysis must be required for each code before it is applied to hospitals. Remember, we are not in disagreement with the goals

or objectives of codes but when costs outweigh benefits derived, then codes should be questioned and definitely not mandated.

6. Utilization Review - In other industries, to insure quality control of their products, corporations, companies, and manufacturers take a statistically valid sample of their product and determine from the appropriate confidence level the quality of their product.

   In the hospital environment, the Federal Government requires us to do a 100% quality control check on our Medicare-Medicaid product which, of course, is patient care. This is very costly. We, therefore, suggest that hospitals be allowed to use statistically valid samples of our patients rather than the 100% check method.

7. Inflation - Just in the first quarter of 1977, inflation has increased 10%. Everything we purchase is affected by inflationary increases. Hospitals should be allowed to pass this cost on to the patient they are serving just as sellers of other services do. President Carter's Cost Containment Act does not allow this.

8. Non-payment of hospital bills - With the increased false implication that hospitals are gouging the public, there's an increase refusal on the part of many patients to pay their hospital bills. Who will pay for the cost of services expended? Just as shoppers at the market place must pay for the cost incurred due to the shop-lifter, so also must other patients and third-party payers pay the cost of unpaid services. We think Congress should enact legislation which would require all non-indigent persons utilizing hospital services to pay their due debts. This would reduce hospital costs.

Over utilization of hospital services, which is beyond our control, is another factor causing increased in hospital costs. Remember, the patient and physician decide when hospitalization is needed. After the patient is admitted, then the hospital can control continued utilization of services. It is possible to predict the rate of illness for a population or group but for the individual it's not possible to predict his rate of illness or when it will occur to him. Therefore, people in our society have a choice. They can save toward a future illness but cannot be sure that they will accumulate a sufficient amount in time for an illness, should it occur. Second, people may take upon them a form of pre-payment to an insurance company, which we now call a third-party payer. The Federal and State Governments are also third-party payers through the Medicare-Medicaid programs. This affects the demand for health care services.

Graph A shows the demand curve for a Medicare patient. You will notice that as the deductible is paid by the Medicare patient, his demand for services increases. The patient demands care for other illnesses or pains which he would have ignored prior to Medicare when the deductible has to be paid.

For the Medicaid or Illinois Public Aid patient, (Graph B), you will notice that the demand curve is perfectly elastic. That is, the patient incurs no personal cost, therefore, he demands an infinite amount of care. This, of course, increases utilization and also increases hospital costs. You can investigate any hospital that services Medicaid or Illinois Public Aid patients and you will find that their doors are like revolving doors, the patient no sooner gets out and he is back again demanding service from both the physician and the hospital.

We demonstrate in Graph C (An Indifference Map separating all other consumer goods and Health Care Services) the increase in utilization of health care by clients of third-party payers, such as, Blue Cross, Employer's group insurance, etc... We assume that the consumer has enough knowledge relative to his consumption decisions. We assume that the consumer regards all groups of goods equal, e.g., health care services and all other consumer goods yield the same level of utility and are equivalent. We assume the consumer has established a rank ordering preference as to how much health care service he wants in relation to all other consumer goods. We also assume that the consumer has a limited amount of financial resources. Therefore, he has a maximum amount he can spend per period of time and has the problem of determining how he will spend these limited resources in a way which will yield him a maximum of satisfaction. These assumptions are made on the basis of Ceteris Paribus.

In Graph C, we show an increase in utilization of health care by decreasing the price of health care through health insurance or the third-party payer mechanism. In this situation, the consumer's budget line or limited financial resource is line A-B on the Graph. Indifference Curve "I" lies tangent to the budget line at point "P" on the Graph. At this point, the consumer will consume H_1 amount of health services and CG_1 amount of other consumer goods to maximize his satisfaction.

The consumer, through his own actions, that of his employer, or through some other means, obtains health insurance. Immediately, the price of health care is reduced. This is reflected by the change in his budget line which is shown as A-B Prime. The consumer is now on a higher or better indifference curve. This is reflected by Indifference Curve "II" which lies tangent to the new budget line at Point "R" on the Graph. At a small sacrifice of other consumer goods CG_2 the consumer is able to buy a greater amount of health care as reflected by H_2.

We suggest, if President Carter and Congress wish to control health care costs, they decrease the utilization of health care. We recommend the government require consumers of health care to pay a deductible on a sliding scale basis, i.e., first dollar coverage for health care would be eliminated. The more serious the illness or hospitalization requirement, the less deductible the consumer would have to pay. Therefore, if the consumer was involved in a true emergent or acute

situation, he would not have to pay any deductible. On the other hand, if the consumer arrived at the hospital demanding care for a non-emergent or non-acute situation, he would have to pay a deductible to obtain treatment at the health care facility. We also recommend this deductible requirement be applied to welfare consumers, i.e., a welfare recipient would have to pay a deductible in proportion to his welfare income if he demanded care for a non-emergent or non-acute illness in any facility other than the physician's office.

This places upon the consumer the responsibility of deciding if his illness is serious enough to pay the required deductible for services outside the physician's office. For example, in Graph D, we show there is an inelastic demand curve for emergency services for both the High Income patient and the Low Income patient.

We can conclude that in life and death situations the demand for health care is close to identical whether the consumer has the ability to pay or does not have the ability to pay. Please remember, Congress must define the quality of health all citizens are to have.

We also recommend President Carter and Congress institute a preventative medicine (Pro-health) program which would be far less costly and would reduce the high cost of hospitalization by eliminating illness and injury before it occurred.

For example, the government could pass laws in which it would require that anyone who smokes would not be entitled to national health insurance benefits, Medicare, or insurance benefits for catastrophe type of illnesses, such as cancer.

Anyone who drinks and drives and causes an accident in which he is injured would not be entitled to third-party reimbursement. Those individuals who do not maintain a clean and healthy environment in their homes as noted by the Welfare services of the various states, would not be entitled to health care or benefits of national health insurance, Medicaid, etc., unless they met the standards as set forth . Those who refuse immunization shots or did not make themselves available for such shots would not be eligible for care if they became inflicted with the disease. Above all, those consumers of health care, who fail to follow their physician's instructions for an illness and required additional hospitalization or health care, would not be entitled to any type of national health insurance or third-party reimbursement. Our point is that preventative medicine would eliminate illness before it occurred, which in turn would decrease hospital costs through decreased utilization.

We feel the overbedding of hospitals will be found in the metropolitan areas and not in the rural areas. We agree there is overbedding, which is a mal-distribution of beds caused by a mal-distribution of physicians.

There is a great quantity of statistics which show that we probably have enough physicians in this country, but our real problem is the mal-distribution of physicians due to the fact that they have become used to the reduction of their

personal time due to large quantities of allied health care manpower provided by the metropolitan hospitals, which at this time cannot be provided by the rural hospitals. Physicians do not want to practice medicine in areas where the allied manpower is not sufficient to subsidize their time in non-professional or non-physician activities. This mal-distribution of physicians is recognized in Red China, Russia, and here in the United States.

We suggest physicians who practice in rural areas be given a tremendous tax break to encourage distribution of physicians to rural areas. We define a rural area as any area 30 or more minutes beyond any Metropolitan area (a population of over 40,000). We suggest this tax break not be a temporary thing; when the law is passed that it be permanent for a least 50 or more years. For example, we suggest for a physician who will practice in a rural area, that 50% of his income after expenses be tax free. This would include Federal, State, County and City taxes. There will be many who would begrudge the physician this tax break, but remember, they paid the price to become physicians. Let those who want the tax break become physicians and practice in a rural area.

We suggest, as a cost reduction incentive for the control of hospital costs, a national binding arbitration requirement be placed on all malpractice claims. For example, if a patient feels he is due damages as a result of a physician's action, the physician's attorney, the hospital attorney, and the plaintiff's attorney, be required to get together to choose an arbitrator who in turn will rule that there is or is not a malpractice claim. It is important the arbitrator be anyone of their choosing. He should not be an individual who arbitrates labor distributes by finding the compromise or the middle of the road course. This will only increase costs. The arbitrator must rule one way or the other. This procedure would reduce the number of out of court settlements made by insurance companies where no malpractice has occurred but where settlements were made at the detriment of the hospital or physician concerned. These settlements were made as economic decisions based on costs and not the issue of malpractice but in turn have increased the number of malpractice claims because people know they will receive some kind of monetary settlement.

We are surprised to find President Carter does not include Federal hospitals in his Hospital Cost Containment Act. These facilities are notorious for misuse and mis-management of money. They budget for a certain amount of money and at the end of the fiscal year if that amount is not spent, they spend it on unnecessary equipment, services, or projects which are not included in the original budget. The purpose of this last minute spending is to ensure they will obtain future increases in funds based upon past expenditures. It is our opinion that Federal and State hospitals should be scrutinized and each Federal and State hospital should be required to meet certificate of need requirements the same as private and not-for-profit institutions. We would like to point out that the individuals who utilize these facilities are like the welfare patient who does not have to pay a price for health care. Again, these people demand more health care than what is really needed. These hospitals have waiting lists which verify this. Many of these Federal institutions are overstaffed and many times with incompetent people who are not able to function in a competitive world or in the real-world of malpractice.

We will be the first to support changes in the hospital reimbursement system which will encourage and reward management efficiencies. We urge Congress to phase out the retrospective hospital cost reimbursement system now under Medicare and Medicaid and replace them with fee for service charges based upon sound Cost Accounting Principles with periodic review. If there is going to be rate-review, then there should be manditory comparison of similar institutions. For example: 50 bed institutions with 50 bed instutions, Children (speciality) Hospitals with Children (or like speciality) Hospitals and Teaching Hospitals with Teaching Hospitals, Rural Hospitals with Rural Hospitals, etc...

We feel President Carter's Hospital Cost Containment Act of 1977 is politically vote getting, emotional, near-sighted, distorted, biased, inequitable and reprehensible approach to the cost escalation problem found in the hospital and health care industry. We are fully cognizant of the fact that some of our suggestions are not vote getting or politically viable suggestions. However, our suggestions would drastically reduce the cost of health care in this country. They would also place upon the consumer the responsibility of this Nation's health, where it belongs.

We sincerely hope you, as a member of our national legislature, will recognize that the hospital is being utilized as a scapegoat for the high cost of health care in this country. We, also, hope that you will see through this distortion, misrepresentation, and the Judas kiss President Carter has given the Nation's hospitals. Please recognize that those hospitals which will be hurt the most throughout this Nation will be those in the rural areas.

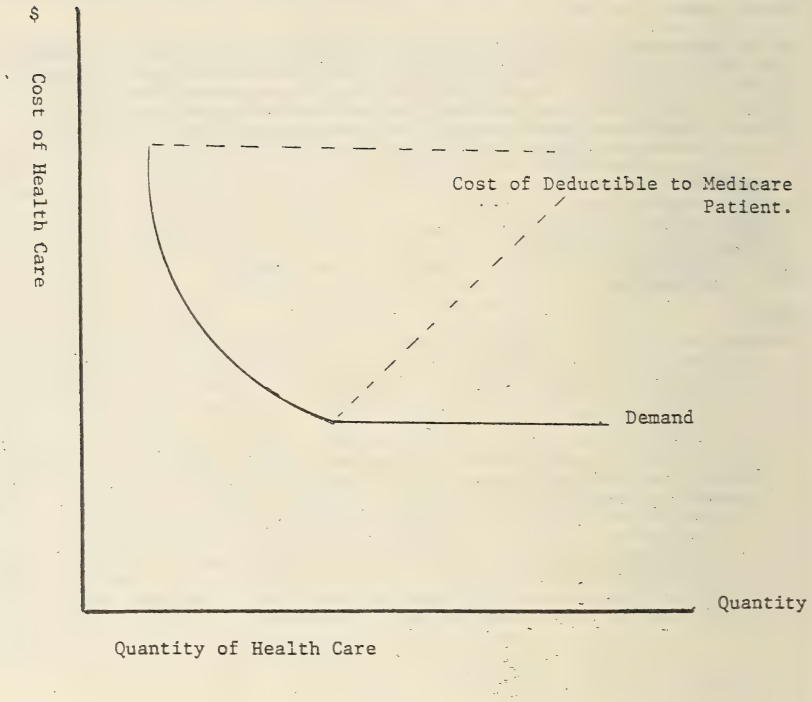
Sincerely,

William M. Reger, III
Executive Director

WMR:fs
Encl. 4

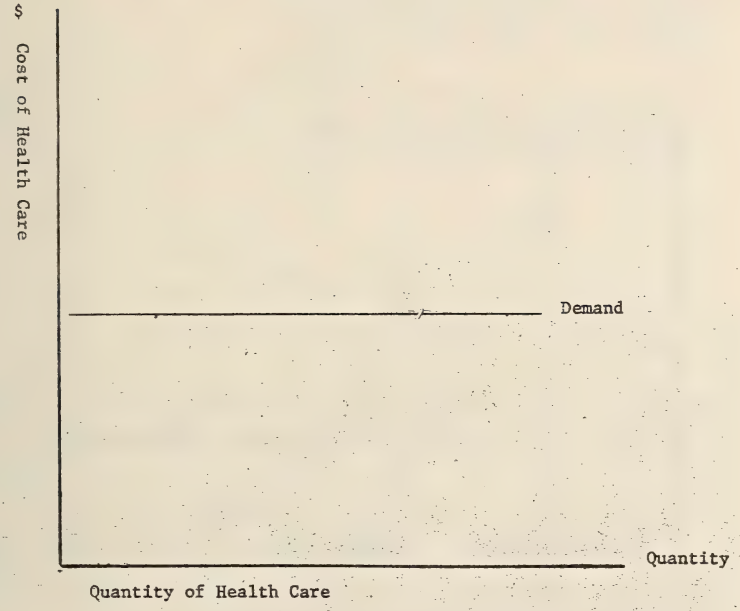
GRAPH A

DEMAND FOR HEALTH CARE BY MEDICARE PATIENT



GRAPH B

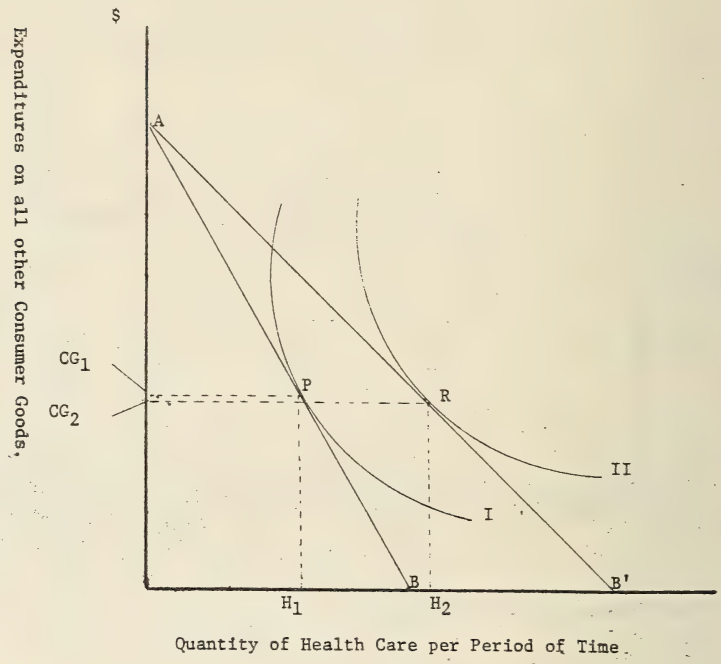
DEMAND FOR HEALTH CARE BY IDPA* PATIENT



*IDPA = Illinois Department of Public Aid

GRAPH C INDIFFERENCE MAP

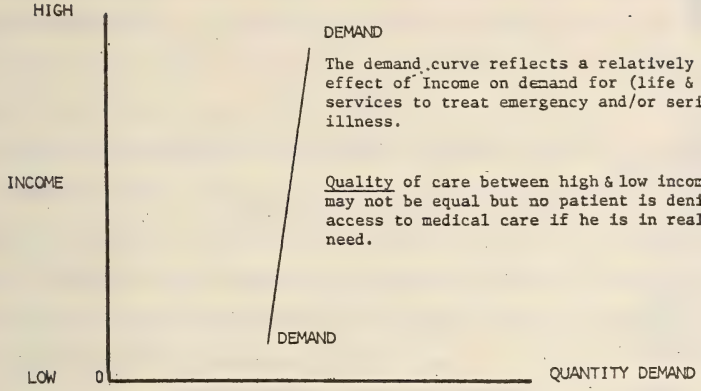
Increase in the Utilization of Health Care through Price decrease caused by Insurance - third party payer mechanism ceteris paribus.



H_1 to H_2 represents the total increase in the consumption of Health Care because insurance causes a price decrease. Therefore, the consumer demands or obtains more because he does not have to pay the full costs of his hospitalization or health care.

GRAPH D

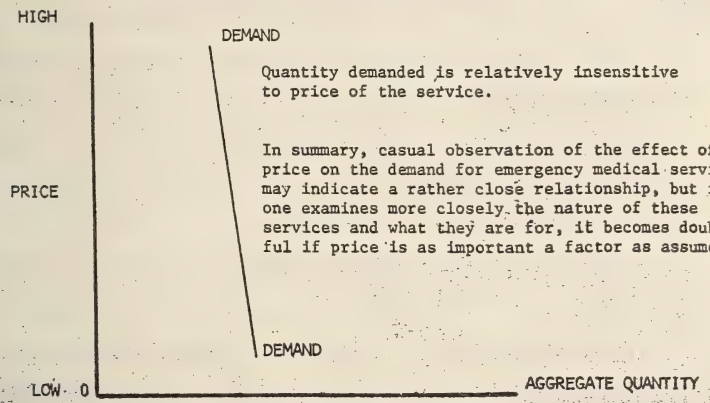
INCOME AND DEMAND FOR LIFE-SUSTAINING SERVICES



The demand curve reflects a relatively slight effect of Income on demand for (life & death) services to treat emergency and/or serious illness.

Quality of care between high & low incomes may not be equal but no patient is denied access to medical care if he is in real need.

PRICE AND DEMAND FOR LIFE-SUSTAINING SERVICES



Quantity demanded is relatively insensitive to price of the service.

In summary, casual observation of the effect of price on the demand for emergency medical services may indicate a rather close relationship, but if one examines more closely the nature of these services and what they are for, it becomes doubtful if price is as important a factor as assumed.

CONSUMER DEMAND FOR LIFE-SUSTAINING HEALTH SERVICES AS A FUNCTION OF PRICE

Bailey, Richard M., An Economist's View of the Health Service Industry, PP 3-18

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STATEMENT OF THE

COMMUNITY SERVICE SOCIETY OF NEW YORK

For the Joint Public Hearing

of the

Subcommittee on Health
of the
Committee on Ways and Means

and

Subcommittee on Health and Environment
of the
Committee on Interstate and Foreign Commerce

ON THE

"HOSPITAL COST CONTAINMENT ACT OF 1977"

May 11-13, 1977

The Community Service Society of New York is the nation's largest and oldest non-profit social service organization. For the past several years, its Committee on Health has undertaken research and anlysis on cost and quality control issues of significance to the U.S. health care system. We have reviewed the proposed "Hospital Cost Containment Act of 1977" and wish to make the following comments.

H.R.6575 recognizes the need to impose objective limits on hospital cost increases, while guaranteeing a timely transition to permanent and comprehensive reform of the health reimbursement system. We believe there is much in the measure to commend, but cannot fully endorse it unless a few flawed provisions are modified. An analysis of selected provisions of the bill and proposals to strengthen H.R.6575 follows.

Inflation Adjustment Formula

The Society has long been interested in promoting the containment of hospital cost increases. Last year, we published a major economic study (Prospective Reimbursement for Hospitals) which presented a specific model for a prospective payment program that would contain hospital costs. In that study, we endorsed the concept of an empirical formula to adjust hospital base costs to reflect forecasted changes in economic conditions. In addition, we argued that cost increases over the approved costs of the base year which are in excess of the inflation factor should not be recognized. Unfortunately, however, we must oppose the "adjusted inpatient hospital revenue increase limit" as defined in H.R.6575.

If the proposed inflation formula were to be implemented as is, it would deserve predictable hospital industry charges of being "arbitrary," "inequitable" and "unworkable." This is so because the formula would use

the GNP price deflator published by the U.S. Commerce Department, which does not measure inflation in the goods and services hospitals must buy. We cannot overemphasize the fact that the GNP deflator is crude, unrepresentative, and inferior to several other hospital price indices and proxies currently in use.

To begin with, the GNP price deflator is not even a price index for a fixed basket of goods. It is composed of selected items from the following categories: intermediate goods, consumer goods and government services. This situation leads to two types of problems: beginning with the second year of application, a non-absolute increase could be registered simply because of changes in the market basket; and the problems hospitals actually encounter are not reflected, especially with regard to energy costs among other specific hospital costs.

We are convinced that H.R.6575 can replace the proposed GNP deflator with available measures that are more workable and methodologically sound. Of course, the development of hospital inflation indices and proxies is an evolving art, but the following systems are more appropriate and relatively sophisticated and should be considered in the development of a national model: (1) The Employee Cost Index recently set up by the U.S. Bureau of Labor Statistics; and (2) The Hospital Price Index used by New York State in its prospective rate program. In the New York index price movements are derived from hospital-related indices and proxies including selected external economic indices, such as the Consumer and Wholesale Price Indices of the Bureau of Labor Statistics; and indices developed by the State Health Department.

Volume Adjustments

Sec. 113 does well in setting forth an automatic, empirical system to account for volume variations in a manner that appears equitable and administratively simple. Revenue increases equal to one-half of average revenue per stay in the base year would be allowed for each increased admission beyond two percent; similarly, revenue decreases equal to one-half of average revenue per stay would be imposed for decreased admissions greater than six percent. While we initially questioned the wisdom of allowing a negative range of up to six percent, we now believe it would be acceptable for the first year of operation because it would present an incentive for reducing admissions. However, the six percent figure should not be used indefinitely because it might produce the negative result of encouraging the dumping of charity care patients and/or more complex or expensive cases. While we recognize and support the intention of Sec. 126 to require hospitals to maintain their charity patient load shares, we believe the problem is a potentially serious one and deserves careful monitoring and enforcement.

In summary, we support the use of volume adjustment thresholds of two percent upward and six percent downward for one year. After that, we recommend that the actual patient volume realized become the base figure for any future years and be reflected in the census forecasts prepared by both the hospitals and the health planning agencies. One additional comment we would make here concerns the exception for small hospitals, which we believe appropriate for facilities in rural and not urban areas. Therefore, we recommend that Sec. 113(1) be amended so that hospitals with no more than 4,000 admissions in the base accounting year should be allowed volume ranges of two percent and ten percent, respectively, only if they do not lie within Standard Metropolitan Statistical Area designations.

Gaps in Coverage

One final objection we would raise concerns the definition of in-patient hospital services covered under the proposal. As we have interpreted it, H.R.6575 would exclude revenues generated from non-hospital based radiology, pathology and anesthesiology services provided to inpatients. This is clearly unacceptable because ancillary services, in general, have become the driving factor behind inflationary pressures in recent years. Our concern is that by exempting such services from revenue limits where they are based outside the hospital, H.R.6575 could stimulate the large-scale contracting out of ancillary services. We recommend that radiology, pathology and anesthesiology services should be defined as hospital-based services for purposes of the Act.

Exceptions and Efficiency Review

Sec. 115 concerning the establishment of exceptions is very well taken. It provides for a timely review of appeals based on limited, well-defined exceptions -- and it supports the role of the planning agencies in assessing what services and facilities are needed. Further, it wisely calls for an operational review by the Secretary and conditions the exception on implementation of recommendations to improve efficiency.

Third-party reimbursement officials and other knowledgable observers have long argued that significant cost savings are possible through improved hospital budgeting (especially as related to staffing ratios) and management in light of overall community needs. By providing management assistance in this manner, H.R.6575 would take this country beyond payment based on arbitrary historical costs and would do much to streamline and rationalize our health delivery system.

Capital Expenditure Limits

Title II of H.R.6575 is on the whole excellent. Clearly, a capital expenditures lid is required in a health system such as ours which is characterized by significant overbedding and duplication of services. It is hoped that the ceilings would be set in a sophisticated and equitable manner, particularly in the long-term, and that state and local planning agency expertise would be sufficiently called upon. In addition, we believe that priority in the allocation of funds should be given to renovations in line with life safety codes.

We note that the proposed occupancy standard may not be less than 80 percent for any fiscal year, and that different standards could be promulgated for health service areas with special characteristics (presumably rural and/or underserved). We would hope that the 80 percent occupancy level figure represents a weighted average of varying occupancy rates applied to the various hospital size classifications and bed categories. Also, based on the extensive research we have seen, not only is a national average occupancy level of 80 percent well within reach, but in many instances it is a little low.

Exemption of Nonsupervisory Personnel

Community Service Society supports Sec. 124, which provides for the exemption of wage increases derived from collective bargaining for nonsupervisory personnel. We support this position because the majority of nonsupervisory hospital workers are still underpaid. It is our view that efforts to reduce hospital cost increases should be targeted at inefficiencies and waste that contribute most to hospital inflation, not the wage increases of nonsupervisory hospital workers, many of whom earn below the Bureau of

Labor Statistics Standard for an austere family budget. It would be inappropriate for these workers to bear the burden for hospital excesses.

In conclusion, we support the basic intent of H.R.6575 and believe it can be a valuable transitional tool toward a better national reimbursement system but would strongly urge that the weaknesses discussed above are addressed. The bill should only be judged a success to the extent it facilitates such a transition. We know from past experiences with the Economic Stabilization Program that when the hospital industry expects controls to be short-term, it will employ temporary measures to comply in preference to needed changes in basic institutional operations. Looking to the future, we recommend that H.R.6575 specifically recommend that the Secretary's report of March 1, 1976 set forth a health cost containment strategy which features a reimbursement system characterized by: (1) prospective budget review; (2) a uniform payment mechanism under a comprehensive national health insurance program; (3) automatic inflationary adjustments based on objective and hospital-related cost criteria; (4) system-wide application of management assistance to correct existing inefficiencies; (5) strong support for the goals of health planning; (6) federal criteria for state health facilities plan emphasizing the need for quality-related renovations/replacement of existing facilities where continued need has been certified; (7) development of federal recertification of need criteria under Sec. 1513(g) of P.L. 93-641; (8) development of uniform hospital accounting and reporting system as well as requirement of full financial disclosure and reporting; and (9) development of incentive system that would recycle a portion of efficiency-derived savings to support needed health services (e.g. ambulatory care).

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HONORABLE E KENNEDY U.S SENATE
SENATE OFFICE BLDG
WASHINGTON DC 20510

YOU ARE URGENTLY REQUESTED TO BE NOT IN FAVOR OF SECRETARY CALIFANO'S BILL, H.R. 6575 AND S.1391, "THE COST CONTAINMENT ACT OF 1977".
RATIONAL:
A. 1. IT IS NOT POSSIBLE TO REGULATE SICKNESS AND ACCIDENT. BASIC AND ECONOMIC PRINCIPLES DETERMINE THAT HOSPITAL REVENUE AND COSTS FLUCTUATE WITH THE NEED FOR IN-PATIENT AND OUT-PATIENT HOUSE CARE.
2. HOUSE CARE PERSONNEL EMPLOYMENT NECESSARILY FLUCTUATES WITH SUPPLY AND DEMAND OF THE SICK AND INJURED.
3. PERCENTAGE OF LABOR COST TO TOTAL COST IS 60 TO 65 PERCENT IN THE HEALTH FIELD-IN INDUSTRY IT IS 20 TO 35 PERCENT. THE RELATIVE COST OF "PRODUCTION" OF HEALTH CARE IS TREMENDOUSLY HIGHER THAN INDUSTRIAL MANUFACTURING OR THE COMMERCIAL FIELD.
4. HEALTH CARE INDUSTRY MUST MEET WAGE/LABOR COMPETITION WITH OTHER ECONOMIC EMPLOYMENT AREAS-OR IT ATTRACTS ONLY LOW QUALITY, LOW PRODUCTIVE AND HIGHER RISK EMPLOYEES.
5 HIGHER WAGE SCALES ARE SET-NOT BY HEALTH CARE FACILITIES, BUT BY MANUFACTURING INDUSTRY, ETC. AND THE U.S. DEPARTMENT OF LABOR AND INDUSTRY.
6. THE HEALTH CARE INDUSTRY WITH ITS HIGHER PERCENTAGE OF EMPLOYEE COST TO TOTAL COST RELATIVE TO OTHER ECONOMIC AREAS IS ADVERSELY AFFECTED BY AN INCREASING COST OF "PRODUCTION" OF HEALTH CARE RELATIVE TO THE GROSS NATIONAL PRODUCT.
B. FACILITIES AND SERVICE: WHILE IT IS TRUE SOME HOSPITALS MAY BE OVER EQUIPPED AND POSSIBLY OVERSTAFFED, EFFORTS SHOULD BE MADE TO LIMIT THE OFFENDERS-AS WE DO IN OTHER JUDICIAL AREAS. YOU ARE ENCOURAGED NOT TO OVERLY REGULATE TO THE DETRIMENT OF THE ENTIRE HEALTH CARE INDUSTRY. IN THIS RURAL HOSPITAL, FACILITIES AND SERVICES ARE PROVIDED ACCORDING TO HEALTH NEEDS OF THE PUBLIC AND TO A LESSER EXTENT TO AVOID LITIGATION.
C. DISCLOSURE OF INFORMATION:THE BILL AS WRITTEN INVITES LAW SUIT-WHICH WILL INCREASE THE COST OF HEALTH CARE.
D. ADJUSTING IN-PATIENT LIMIT: THERE IS NOT A MAJOR HOSPITAL WITHIN 32 MILES OF THE CORRY MEMORIAL HOSPITAL, CORRY PENNSYLVANIA. DURING THE YEAR CENSUS VARIES IN SERVICES AND IN TOTAL FROM 35 PERCENT TO OVER 100 PECENT OCCUPANCY TO COMPLY WITH THIS BILL, WE TRULY BELIEVE THE LIVES OF SOME PATIENTS WOULD BE PUT IN JEOPARDY.

REPEAT: THE LOW PERCENTAGE OF HEALTH CARE FACILITIES WHICH NEED CENSURE SHOULD BE CENSURED SECRETARY CALIFANO'S BILL (H.R.6575 AND S.1391) SHOULD BE DEFEATED AS NOT BEING APPROPRIATE TO THE NEED; AS BEING HARMFUL AND COSTLY TO THE PUBLIC AND TO THE MAJORITY OF HEALTH CARE INSTITUTIONS. PASSAGE OF THE BILL WOULD LOWER THE PRESENT QUALITY LEVEL

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OF HEALTH CARE.

ON PASSAGE OF BILL H.R.6575 AND S1391, YOU I RESPECTFULLY REQUESTED TO VOTE NO. RESPECTFULLY YOURS

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PRESIDENT CORRY MEMORIAL HOSPITAL
RAY AMY, CHAIRMAN, BOARD OF TRUSTEES
R. ELWIN FULLER SECRETARY BOARD OF TRUSTEES
GERALD R LLOYD M.D. PRESIDENT MEDICAL STAFF
MRS RUTH JOYCE PRESIDENT AUXILIARY

12:19 EST

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BI-COUNTY COMMUNITY HOSPITAL, WARREN

June 15, 1977

Stuart Shapiro, M.D.
Office of The Honorable Edward Kennedy
The United States Senate
431 Russell Office Building
Washington, D.C. 20510

Dear Doctor Shapiro:

I am sorry your schedule was such that you were unable to meet with some of our executives when we were in Washington recently; however, being aware of the extremely busy docket of the Congress and its Committees, I fully understand your not being available.

We had hoped to review with you our position on various matters of pending or future legislation since we sincerely feel it is the dialogue of mutual concerns of legislators, planners and providers that makes for effective legislative programs.

Enclosed is a copy of the Position Paper we had hoped to discuss with you. If you have questions regarding any of the items, please contact me and we will provide additional information.

I would also like to express our willingness to offer your Committee any feedback you might desire from personnel working with the day-to-day problems in health care.

It is our hope that we can meet with you at some future date to discuss, personally, some of our thoughts and concerns for the future of health care delivery. I will contact your office to see if such a meeting can be arranged when we plan to visit Washington again.

Sincerely,

Jean Carey

Patricia Jean I. Carey
Administrative Assistant
to the Executive Vice President

/brh

Enclosure

DETROIT OSTEOPATHIC HOSPITAL CORPORATION

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May 23, 1977

POSITION STATEMENT ON FEDERAL LEGISLATION AND REGULATION

1. PROPOSED COST CONTAINMENT LEGISLATION (HR 6575): We advocate cost containment by hospitals. Nevertheless, we strenuously oppose the Administration's Cost Containment Act. The bill fails to address the major problems affecting health care costs. It penalizes already efficient and well-managed hospitals and politicizes the planning process and impedes the restructuring of our health system. Hospitals are only one of the participants that contribute to hospital costs yet the Resolution ignores all other segments. It caps reimbursement payments while the cost of resources is unregulated which will ultimately result in diminished quality of care.

2. COMPARATIVE STATISTICS REGARDING INFLATION: The Consumer Price Index does not account for intensity of service and thereby distorts the inflation of hospital costs. We recommend adoption and support of statistical comparisons developed by the American Hospital Association titled the Hospital Cost Index and Hospital Intensity Index.

3. MINIMUM WAGE LAWS (HR 3744): DOHC endorses the social concept of raising minimum wages but opposes this legislation because of the impact on hospital cost. Increased hospital costs combined with "caps" on reimbursement will simply reduce the quantity of labor utilized. The minimum wage tied to automatic indexing based on any specific industry will escalate costs even more.

4. MEDICARE AND MEDICAID REFORM: FRAUD AND ABUSE/PSRO (HR 3): DOHC supports legislation that would eliminate fraudulent practices in all health care programs. We oppose Section 11 of HR 3 making Medicaid the "payor of last resort." Section 5(j) of HR 3 making provision for PSROs legal liability to be assumed by the Secretary should also be extended to hospitals in a fully delegated hospital performing PSRO activities.

5. NATIONAL HEALTH INSURANCE: DOHC supports NHI. It recommends inclusion of health care providers, business, and labor in the development process; incentives for cost containment; and, payment of full financial requirements to hospital providers. It should not be supported by tax revenues but should have multilateral involvement and have time phase implementation. A gradual approach utilizing less regulation and more coordination at the federal level should be used.

6. UNIFORM ACCOUNTING AND REPORTING SYSTEMS (HR 4211): A uniform accounting system should not be mandated without a thorough analysis weighing its benefits against adverse consequences. Hospital management's information needs are primary, not secondary, to the information required for external reporting purposes. External requirements for uniform information can be met by developing uniform reports with uniform definitions.

7. AMENDMENTS TO INCLUDE HOUSE STAFF UNDER NATIONAL LABOR RELATIONS ACT (HR 2222): Interns and residents are graduate medical students in educational programs. Their presence in hospitals is for medical education and experience. Programs are regulated by voluntary accrediting agency, federal and state laws, and should not be modified through the NLRAs prescribed collective bargaining process.

8. CLINICAL LABORATORY IMPROVEMENT ACT (S.705): DOHC opposes this legislation because of its cost implications on hospitals. It will impose another extensive and expensive regulating apparatus which is not needed. When an extension of laboratory regulations was proposed in Michigan, it was defeated because labs were already over-regulated and it would increase cost. Federal legislators should take their lead on this from the State of Michigan.

9. COMMUNITY MENTAL HEALTH CENTERS: DOHC strongly supports continuation of the CMHC program and urges a simple one-year extension for 1978 with an eventual amendment which would no longer require hospital based CMHCs to establish an independent governing board.

10. CONGRESSIONAL REVIEW OF ADMINISTRATIVE RULEMAKING: DOHC supports any legislation that will simplify this regulatory process and guarantee opportunity for input from our industry. We are concerned about the heavy burdens imposed on the health care delivery system through the administrative rulemaking process. A multiplicity of federal and state agencies and departments issue regulations directly impacting day-to-day operations. The current process causes increasing frustrations, bewilderment, and dismay.

FLORIDA HOSPITAL ASSOCIATION
INCORPORATED
P. O. BOX 6905 / 315 PARK LAKE CIRCLE / ORLANDO, FLORIDA 32803 / (305) 841-6230

June 17, 1977

The Honorable Edward M. Kennedy
Chairman
Subcommittee on Health and
Scientific Research of the
Senate Human Resources Committee
431 Russell Senate Office Building
Washington, DC 20510

Gentlemen:

Enclosed is the statement of the Florida Hospital Association on behalf of its member hospitals relating to S. 1391 - The Hospital Cost Containment Act of 1977.

Thank you for the opportunity of providing this testimony for the record.

Sincerely,

Jack F. Monahan, Jr.
Executive Vice President

JFMjr:jah
Enclosure.

Statement of the Florida Hospital Association
To the Subcommittee on Health and Scientific Research
of the Senate Human Resources Committee
On S. 1391 - The Hospital Cost Containment Act of 1977

The Florida Hospital Association represents 230 member hospitals, including approximately 90% of the acute care beds in Florida. We appreciate the opportunity to share with you our views on S. 1391 and to specifically address the issues which appear to almost uniquely affect Florida.

The Florida Hospital Association strongly opposes enactment of S. 1391. We are satisfied that S. 1391 is so conceptually wrong that it should be completely discarded and an entirely different approach considered. Price Controls (or revenue limits as the administration prefers to call them) have time and again proven to be an unsatisfactory method for solving inflation problems. Price controls on one segment of the economy have not only proven unsatisfactory but impossible.

Some areas of major concern with S. 1391 (in the order they appear in the bill) are:

TITLE I - TRANSITIONAL HOSPITAL COST CONSTRAINT PROVISIONS

TRANSITIONAL BILL

While this bill is constantly referred to as a temporary or transitional bill, we note that is does not expire until the adoption of permanent reforms. Permanent reforms which will accomplish effectively what this act would accomplish are impossible unless everyone involved acknowledges that access to hospital care needs to be

reduced. The administration, sponsoring this movement toward less access to hospital care, should be informing the public what types of care will no longer be available.

PURPOSE OF THE BILL

To constrain the rate of increase in total acute care hospital inpatient costs by limiting the amount of revenue which may be received -- is a little like telling the housewife that we're going to hold down the cost of food next year by limiting your household's income -- to be sure, she would probably spend less for food but it would be either in the form of reduced quantity or quality or both.

IMPOSITION OF THE INPATIENT REVENUE LIMIT

The whole concept of using uniform limits on increases in revenue is, of course, punishment for the most cost-effective hospitals and reward for the least efficient. This has been acknowledged by representatives of the administration.

The retroactivity of the limitation to fiscal periods as far back as 1976 will prove impossible to live with, particularly for hospitals where expansion has taken place (either in beds or services). This is a problem of particular significance to Florida because of the tremendous growth in the hospital industry in recent years. There are many reasons for this growth, including among others, Tourism, Population increases, Aged population, Retirees under age 65 (often for health reasons) etc. The expansion in beds and services which has already occurred cannot be eliminated, however the proposed program in no way recognizes this situation. There is also no turning back the increasing population in Florida. The imposition of the limit as outlined in the bill is most kindly described as inequitable and probably more real-

istically classified as unbelievable. Surely the result was not intended. The cumulative approach of adding each year's promulgated revenue increase limit to the preceding amount allowed and applying it to a base year of 1976 continually dilutes even the inadequate amount allowed. Within a very few years the percentage increase allowed will be significantly less than even the GNP deflator.

ADJUSTED INPATIENT HOSPITAL REVENUE INCREASE LIMIT

There are several serious inequities in the formula approach to developing an inpatient hospital revenue increase limit. First - the use of the implicit price deflator of the gross national product as a measure of inflation. This measurement while it may be a good measure of inflation in the economy as a whole, does not proport to reflect the "market basket" of a hospital. The inflation in the hospitals' "market basket" has been significantly different from the inflation measured by the GNP deflator during the last several years and this difference is clearly evident. Second - the use of the average annual increase in total hospital expenditures as a measure of inflation plus growth. While this may be a laudable endeavor, actually arriving at a meaningful figure from 6,000 plus hospitals (including definitions, reporting forms, systems for the accumulation of data, developing the retroactive or historical base, etc.), may be an impossible task. The data are not presently available. Third - the removal of two-thirds of the hospital growth (based on the average for the previous two years). This concept of uniformly nationwide, reducing the expansion of services does not take into account the fact there may be some need for expansion.

In a state like Florida this would represent many serious problems because of tourism, age of population, and of course most significantly, increasing population (and the

increasing number of people moving to Florida for reasons of health). Fourth - the concept that one national percentage, representing both inflation and growth needs, can be meaningful when applied to even 50 different states let alone 6,000 plus individual hospitals is impossible for us in Florida to accept. The inflation as well as the need for expansion is completely different in a rapidly growing state like Florida compared to farm country like Iowa or the industrialized northern states like Massachusetts. When you go even further into some of the fastest growing communities in the country such as Ft. Myers, Florida, the inequities in this approach have to be evident. Fifth - the use of the GNP deflator rather than the actual change in the GNP means that only inflation is recognized. The mathematics of the formula means that hospitals' share of the GNP would actually decline making the United States the only country in the western world in this position. Sixth - the application of the admission load formula to the national percentage (the promulgated "inpatient hospital revenue increase limit") for each individual hospital. Again in a growing state like Florida the application of this admission load formula would mean that on an average the 9% would become approximately 3% in the first full year under the program and less than 1% in the second year on a per admission basis. This is based on an assumed annual 5% increase in admissions per year since 1976. Actual increases in Florida during the years 1973, 1974, and 1975 were greater than 5% per year. Data for 1976 are not yet available.

THE ADMISSION LOAD FORMULA

The admission load formula is designed clearly to provide hospitals with an incentive to reduce admissions. Where a hospital has unnecessary admissions this is a laudable objective. However where a hospital has no unnecessary admissions (where a strong utilization review committee exists for example), reducing admissions is not a laud-

able objective. The proposed program however applies the same pressures to both. Additionally, in a community with rapidly growing population, increasing tourism, etc., decreasing admissions cannot even be a consideration.

The assumptions in the admission load formula are incorrect. It assumes erroneously that a 2% increase in admissions can be handled for no increased dollars of revenue (supply costs alone belie this assumption). It further assumes a 50% fixed-variable cost split which to our knowledge has absolutely no basis. Obviously large increases in admissions would have a different fixed-variable ratio than small increases because of personnel requirements alone - however this formula does not recognize that fact.

Once again the admission load formula is significantly more damaging in growing states like Florida because of an almost guaranteed inability to reduce admissions.

BASE INPATIENT HOSPITAL REVENUE

The use of 1976 as the base year for control purposes clearly makes many provisions of this bill retroactive in nature. Many changes and expansions have taken place during 1976 and since. These changes not being in base year figures, make the retroactive nature of this bill clearly inequitable. It should be pointed out that most of these changes and expansions cannot now be rolled back.

EXCEPTIONS

The exception provision of this bill is clearly designed to eliminate virtually all exception requests. While certainly this would hold the administrative costs in this area to a minimum, it also makes the exception process more comical than real.

There are only two reasons recognized for which exceptions may be granted. They are (1) more than a 15% increase in admissions in a large hospital and (2) changes in capacity or character of services, or major renovation or replacement of physical plant (but only if those changes alone caused the cost per admission to increase more than the growth factor portion of promulgated "inpatient hospital revenue increase limit". This is regardless of how much that growth factor was diluted by application of the load factor). Going bankrupt for any other reason is not acceptable as a basis for requesting an exception.

Even if you meet one of the two requirements above, you may still not request an exception unless your hospital is less solvent than 75% of the hospitals in the nation. It is easily conceivable in many areas of the country that a hospital might be in a negative cash flow position and therefore unable to pay its bills long before reaching that low level of solvency.

If you have one of the two allowable reasons and you meet the insolvency requirement you still have another requirement to meet before you may apply - that is you must have state agency approval (apparently whether or not it is required - the state agency does not normally approve increased admissions).

After considering all the above requirements before even being allowed to request an exception - there are no criteria at all in the bill governing the secretary's requirements for denying the request.

If the exception should be granted, the additional revenue allowed is dictated by the bill and the amount dictated in many instances would not be sufficient to keep the hospital fiscally viable and may not even reverse a negative cash flow position.

The administration has indicated that it does not expect many requests for exceptions to be filed and we must agree. The stringent requirements and the limited value of the result make the exception process a virtual farce.

We believe the requirement to use up assets to the point of being less solvent than 75% of the hospitals in the country before being allowed to even request an exception, would in many instances force trustees of hospitals to be unable to live up to their responsibility for the safeguarding of hospital assets and it would be extremely detrimental to the communities in which those hospitals are located.

ENFORCEMENT

The application of the limits to each class of purchaser will present some virtually insurmountable problems for hospital administration. The ability to monitor on an ongoing basis the cost or the charge by class of payor, taking into account such things as change of patient mix, change of member (or subscriber) mix for the class purchaser, even change in benefit mix by the class purchaser, will be an absolute impossibility. While policing these limits after a year is concluded might be possible, avoiding the consequences during the year would not.

EXEMPTION OF NON-SUPERVISORY PERSONNEL WAGE INCREASES

The pass through provision for non-supervisory wage increases which exceed the allowed control level is very misleading. It would appear to encourage non-supervisory personnel to seek greater wage increases which in turn would cause extreme problems in several other areas. Obviously such increases would induce justifiable demands for comparable increases from employees for whom such increases could not be passed through. Mathematically, a pass through reduces the amount allowed for growth in the promulgated "inpatient hospital revenue increase limit" (in the

case where 50% of the hospitals' cost was non-supervisory wages, a 3% allowance for growth would be reduced to 1½%).

Whatever the intention was in providing this pass through, it appears that it could not be reasonably assumed that hospitals could afford to use it and therefore the provision is not really useful.

SOME GENERAL COMMENTS ON TITLE I OF THE ACT

While the administration encourages better fiscal planning and more efficient operation of hospitals, this act would make budgeting almost an impossibility. Hospitals today are working on budgets for fiscal years beginning October 1, 1977 and under this program they would not know what their revenue limit was until the fiscal year began. Hospitals with other fiscal years would be even worse off for planning purposes. (A hospital with a fiscal year beginning July 1, would not know the revenue limit for their fiscal year until after three months of it had already passed).

The requirements under this bill for HSA's to handle many new tasks will certainly present some problems for them. It appears some of the tasks are in areas where they were not previously required to develop any expertise. On the other hand, the HSA's may be glad to have some tasks assigned to them since their workload for capital expenditure review would certainly disappear under this bill.

The complexity of the approach, the paperwork which would be required to accomplish the desired result, the impossibility of the mix problems by class of payor as well as by degree of illness, all add up to an unrealistic approach to the problem. This approach completely ignores the controls which already exist and it also completely ignores the reasons for hospital cost increases. It further is blatantly un-

fair in setting price controls on one segment of the economy with no consideration at all of the increasing expenses of that segment. It even further places price controls on only one segment of the health field which clearly would cause some shifting in patterns of health care which may be neither desirable nor economical.

In summary the whole approach is fraught with disaster and should be completely discarded. If we are ever to truly face the problem of rising health care costs we must first face the problem of what the public expects and demands - just as we are trying to do in the energy crisis.

TITLE II - LIMITATION ON HOSPITAL CAPITAL EXPENDITURES

A. HOSPITAL CAPITAL EXPENDITURE LIMIT

The establishment of a national hospital capital expenditure limit not to exceed $2,500,000,000 presents some serious problems: (1) The maximum amount itself has been acknowledged to be no more than half the current amount. To remove 50% or more, of not only expansion of beds and services but also of maintenance of present facilities and equipment has to reflect very little consideration of the long-term effect on the health delivery system. (2) In an inflationary economy the $2,500,000,000 maximum has less purchasing power as each year passes. Building and equipment indices of prior years show that the purchasing power of those dollars will be substantially less than 50% within ten years. (3) Limiting the ability of hospitals to add new technological equipment will very likely force that equipment into non-controlled segments of the health field. This shift will often times be neither desirable nor economical.

The method of apportionment to states also presents problems: (1) The first 18 months of the program calls for apportionment strictly on the basis of population. This simplistic approach, even for 18 months, must be rejected. The failure to consider the percent of the population over 65 (who use the hospital twice as often and twice as long) and the amount of tourism (in Florida we have an average of 10% of our population in tourists every day - not even recognizing peaks) is unconceivable. (2) The failure even after 18 months to require specific considerations in the apportionment and especially the failure to recognize the impact of tourism would make equitable apportionment very unlikely.

If Title I of the act were to be adopted, Title II would be unnecessary since no provision is made in the revenue controls to allow for an increased revenue to finance capital expenditures. The restrictions are such that financing arrangements for capital projects would be virtually impossible. Even the replacement of existing major equipment would be almost impossible under this proposal.

B. NATIONAL CEILING FOR THE SUPPLY OF HOSPITAL BEDS

The establishment of a national ceiling which may not exceed four hospital beds per one thousand of population is once again an unbelievable simplistic approach to a relatively complicated problem. Four beds per thousand in a rural area where few physicians practice would be an utter waste, while on the other hand four beds per thousand in an urban area near a medical school where hundreds (maybe thousands) of physicians practice would not nearly meet the needs.

Using population only as a base in no way recognizes the Florida situation. In addition to the number of practicing physicians, the number of people under age 65 who

retire for health reasons, the rapidly increasing population of all ages, the percentage of the population over age 65, the increasing percentage of the population over 65, the number of tourists in an area on any given day (recognizing peak tourist seasons), are all items which significantly affect the need for hospital beds in Florida. Using an exception approach to solve these kinds of problems has never been satisfactory in the past and there is no reason to assume it would solve these problems in the future.

C. OCCUPANCY STANDARD

The establishment of a minimum 80% occupancy standard again does not reflect a realistic assessment of the situation. An 80% occupancy in an area where tourism has a peak season is a completely unrealistic goal. An 80% occupancy in a rural area where the death or even illness of a single physician could dramatically affect it, is also completely unrealistic.

The standard applied to health service areas individually, means that if the public does not use a hospital (poor care, exorbitant prices, or any other reason), and that fact alone causes the area to have less than an 80% occupancy rate, this standard would force people to use the undesirable hospital before any new beds could be provided.

Again, the use of an exception approach is not a satisfactory solution to these problems.

D. GENERAL

The entire Title II has been acknowledged by representatives of the administration as an overall freeze on capital expansion. It would certainly be more understandable to state the proposal in those terms.

Title II seems to completely ignore the planning law (public law 93-641) which has attempted to set the appropriate planning mechanisms in operation. The health systems agencies are basically in place, and they are attempting to face realistically the problems itemized above. It simply does not seem appropriate at this time to destroy that effort.

ALTERNATIVE CONSIDERATIONS

The American Hospital Association has offered several alternative considerations to the administration's proposal and we concur with those suggestions.

Florida's hospitals are governed by hundreds of thoughtful and responsible citizens. They, through hospital management are making efforts to reduce costs. They have no influence over inflation, over population growth, over increased demands for service. Yet these are the "culprits".

The administration's efforts, as well as those the congress enacted previously, such as Professional Standards Review Organizations and Health Systems Agencies are designed to ultimately reduce the incidence of hospital use. Yet little effort has been made toward telling the people that reducing the use of the hospital is the most certain way to reduce total hospital costs.

Planning and capital controls. We have cooperated in the development of comprehensive planning with emphasis on local planning activities together with certificates of need. Florida was one of the first states (1972) to pass a certificate of need law. The legislature, however, delayed implementation of the statute until July 1, 1973. We recognize that more needs to be done in planning and that adequate support for such efforts must be maintained.

There is a problem of excess capacity in some areas. We believe that the approach included in the Medicare-Medicaid Administrative and Reimbursement Reform Act provides initial steps for assistance to institutions in the conversion, moth-balling or closing of excess capacity. However, the current growth pattern in Florida suggests that by 1980 there will be no excess capacity, and we shall then look with pride on having built our necessary hospital physical plant at early 1970-1975 prices.

Anti-fraud and abuse legislation. We support the fraud and abuse provisions in line with action presently under consideration in the House of Representatives. We believe that the incidence of fraud in hospitals is extremely low. In fact fraud in Medicaid and Medicare by hospitals is rarely alleged in Florida.

Utilization controls. In spite of general opposition from hospital medical staffs, hospital management has made every effort to provide the utilization control mandated by Medicare/Medicaid legislation and to cooperate with PSRO's. Hospitals were given no role in the development of PSRO's, yet at the hospital level have been responsible for implementation of utilization controls. Data from PSRO and UR activities should be helpful in locating areas of over-utilization. Seldom is a patient, however, convinced that he or she was an "over-utilizer".

Public Disclosure. We believe that public disclosure of hospital fiscal data would provide the public the information to make decisions relative to hospital service, and provide better understanding of hospital costs. However, in our experience, the public would tend to want to use the most expensive facility under the assumption that high cost means high quality. Such disclosure could have a negative effect, unless limits are placed on insurance or government program benefits in higher cost facilities.

Payment controls. Reform of methods of making payments to hospitals is a key issue under discussion now. In the Medicare-Medicaid Administrative and Reimbursement Reform Act, an approach is presented for making payments to hospitals which deserves consideration. We support proposals for incentive payments. However, should the public desire to support and use the higher cost hospitals, they should be given the opportunity to pay out of their own pocket for the higher cost service. Safeguards must be developed which will prevent the movement of hospital service to a single level of mediocrity which is inherent in "target" cost programs.

Patient demand. It just may be that the public wants more, not less health care. Yet all government programs seem to be aiming toward less care. Even the highly touted HMO's are a device to provide less health care, yet they are seldom recognized for that attribute.

No one has been willing to attack patient demand as a culprit in our present dilemma, except the government programs that seek to limit hospital revenue by requiring the hospital to be the instrument for limiting patient access. Co-payment must be considered as an appropriate mechanism for diminishing patient demand.

Patient insistence for 24 hour emergency service in hospitals has resulted in an inefficient use of physician manpower, and resultant increase in health care costs, yet the patients continue to flow to hospital emergency service departments.

Patient demand for physician services seems to be insatiable. More physicians means more patient visits which means more health care, but more hospital care as well. While restrictions are suggested for hospital expansion, few are willing to suggest that we have too many physicians.

Government regulations. Government must analyze its own regulations, and regulations which increase costs without adding commensurately to the quality of patient care should be recinded. Yet the flow of regulations continues unabated, even from an administration committed to cost effectiveness.

Personal health responsibility. Finally, while recognizing that it is a difficult task, we must encourage more personal health responsibility through health education.

CONCLUSION

We have gone into great detail to show that our opposition to S. 1391 is based on real problems with the administration's simplistic approach to solving a complex problem. We are completely convinced that the concept of this program is so unrealistic that no effort should be expended to salvage it.

In conclusion we believe that the congress has already set in motion the forces which will affect hospital costs, planning, utilization control, limitation on costs under Medicare-Medicaid, health education, etc. These mechanisms must be strengthened.

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STATEMENT OF THE GEORGIA HOSPITAL ASSOCIATION
TO THE HEALTH SUBCOMMITTEES OF THE HOUSE COMMITTEE ON WAYS AND MEANS
AND THE HOUSE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE
ON H.R. 6575, THE HOSPITAL COST CONTAINMENT ACT OF 1977
For the Printed Record
May 25, 1977

Dear Mr. Chairman:

The Hospital Cost Containment Act of 1977 (H.R. 6575 and S. 1391) represents another in a long series of federal programs/regulations that will undoubtedly become a part of the problem of rising health care costs, rather than the remedy it is claimed to be.

Since the introduction of H.R. 6575 on April 26, 1977, the Georgia Hospital Association has been actively engaged in statewide efforts to receive information and input on the Association's position. Through four meetings for all member institutions, the Association has heard from its members and their governing boards as they expressed their opposition and suggested alternatives to this proposed legislation. We will present in this statement the statewide opposition viewpoint as well as some viable alternatives as recommended by hospital administrators and trustees.

The Georgia Hospital Association totally opposes the Hospital Cost Containment Act of 1977 and urges its withdrawal from further legislative consideration:

It is inequitable and unfair since the Act addresses only the hospital costs component in the health care delivery system. The economics of health care show that such a punitive and arbitrary effort would be unworkable.

The suggested start of October 1, 1977, is unrealistic for such a complex program. The regulations, not yet written, would be hastily conceived and short of soundness.

Of the 153 community hospitals in Georgia affected by H. R. 6575 there are 92 hospitals with less than 100 beds. These are the institutions generally called "small hospitals". H. R. 6575 would place severe restrictions on their revenues at a time when they desperately need to improve their fiscal situations. H. R. 6575 would place many, if not most, of these hospitals on the brink of insolvency in the first year.

These "small hospitals" are not adequately staffed to administer the demands of H. R. 6575 and therefore in order to be in compliance would need to incur heavier costs for additional expertise at a time when they are under order to "avoid additional expense or suffer a heavy penalty."

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The bill penalizes hospitals for increases in bad debts and free care. The bill applies to gross revenues. Bad debts and free care therefore will be charged against the hospital's allowable revenues as if they represented real revenues, when in fact no revenue is realized. An increase in the percentage of bad debts or charity patients could cause a hospital to be out of compliance if, as would be necessary, it increased its revenues to recoup the costs associated with these additional nonpay charges. Over 100 Georgia hospitals received Hill-Burton funds. Annually these (Hill-Burton) hospitals provide free/charity care or uncompensated services valued at about $100 million. The continued provision of free care and/or uncompensated services under the limitations of H. R. 6575 would seriously impair the fiscal viability of these institutions.

For these reasons and others, we agree with the American Hospital Association that H. R. 6575 is unsound in concept: it unfairly regulates one segment of the economy while the rest goes unregulated; it ignores the reasons for cost increases, the planning process, and the cost-saving implications of existing laws such as P.L. 93-641 and P.L. 92-603; its complexity is such that implementation would require a huge bureaucracy that in itself would increase health care costs; it virtually eliminates medical progress while leading to a reduction in existing services.

We call to your attention and most serious consideration the recent report of the President's Council on Wage and Price Stability (December 1976). It said, in part: "It is all too apparent that right now, with current reimbursement programs and the ubiquitous and often conflicting morass of regulations, that the federal government, instead of being a part of the solution, is part of the problem of rising health care costs. This sorry state of affairs has come about despite the best of intentions of government. To add yet another layer of cost-raising regulations , which would inevitably accompany any federal efforts, would be to compound the existing problem."

Even as H. R. 6575 is under consideration,there looms, for hospitals and others, (1) a sizable increase in federal minimum wage,and the President's suggestion that (2) Social Security taxes apply to all wages,and (3) within a few years that the tax base be increased. This is mentioned to emphasize that all three proposals would force health care costs even higher.

There are numerous sections of the bill that could be attacked as unfair, inequitable, and ill-conceived and it is not our intent to go into detail on each such section. But one we must attack and oppose with strong emphasis is the heavy impact of the bill on the very efficient hospital. This is totally inequitable in that the base year proposal would amount to a penalty for those hospitals that excelled in operating efficiencies that year.

Another intolerable requirement is the demand placed upon most hospitals to prepare their budgets for the next fiscal year (with variable periods) without knowing what their revenue limitations are for that period. This, in itself, would result in involuntary noncompliance and make the hospitals liable for retroactive paybacks and likely penalties, with likely horrendous requirements to establish and monitor a patient escrow account in subsequent years for appropriate fiscal juggling purposes.

The exception process in Title I of H. R. 6575 would create further financial hardships for the hospitals, large and small. For example, if a 400-bed hospital in Georgia is denied additional revenue because the GNP deflator increase was less than 1 percent, this could amount to a loss of at least $120,000 (at 3/4 percent increase); a 150-bed hospital could lose at least $75,000; and a small 65-bed

hospital would lose at least $15,000. This represents another major weakness in the proposed legislation that should not be overlooked. It is yet another example of placing hospitals on the brink of insolvency.

An additional example of the impact of this bill upon a Georgia community hospital if enacted,closely focuses on the absurdity of the bill's control and limits on the various management prerogatives of the institution.

The letter from this 500-bed hospital in the Atlanta area states:

"We have studied President Carter's Cost Containment Act of 1977 (H.R. 6575/ S.1391) With the assistance of our independent auditors, we have estimated to the extent now possible how the Act could affect the operations of _____ Hospital. Some of our initial observations are that:

> "Beginning October 1, 1977, inpatient admissions will have to be limited to 21,198 although we now estimate 21,737 admissions. To admit the additional 539 patients forecasted above, the 21,198 would cause a loss of revenue (income) of approximately $530,000 in fiscal 1978. Since we would be unable to sustain such a loss, the Authority would be compelled to limit inpatient admissions to the 21,198. The other 539 patients will have to be sent elsewhere or put on a waiting list until the next fiscal year.
>
> "While the Carter administration has claimed that this bill would limit inpatient revenue increases to 9 percent, in our hospital it would limit them to between 4.9 and 6.8 percent in fiscal 1978, depending on the final interpretation of the bill. While the hospital could only increase its revenues by a maximum of 6.8 percent, the May 8, 1977, ATLANTA JOURNAL AND CONSTITUTION carried an article stating the _____ Company is requesting a 19 percent hike in rates..."

The exception process has many other weaknesses such as the requirement that would force hospitals to liquidate unrestricted investments such as stocks and bonds and use them to pay costs and that the hospital endowments also be depleted before it could apply for an exception. This requirement would surely result in lengthy legal procedures based on government's "confiscation of private property." Furthermore, this requirement would discourage philanthropic gifts to hospitals, and again place the government in the position of being part of the problem of rising health care costs rather than the solution to same. The loss of philanthrophy in the health field would place additional burdens on all payers.

During the conclusion of one of our Association review meetings on H. R. 6575, a hospital trustee (farmer) summarized his frustrations and feelings on H. R. 6575 as follows: H. R. 6575, if passed, will set the New South back by 20 to 25 years.

ALTERNATIVE CONSIDERATIONS:

Our Association membership has been actively involved in the repeated federal/state/ business and community reforms, revisions, new hopes and objectives which have exploded in the scope and demand for health services from all sectors since the inception of the medicare and medicaid programs.

Our membership has a continuing commitment to seek solutions to our state and federal problems of health care costs.

There are no easy solutions or quick answers. To suggest that they will come in five months, or a year, is sheer folly. However, based upon the views of a substantial number of our membership, we wish to stress several major alternatives for reforms that are more promising than H. R. 6575.

PLANNING AND CAPITAL EXPENDITURES:

As others have stated, Title II (as a non-transistional requirement) assumes that the recently instituted planning process will not work.

In less than two years Georgia has established seven Health Systems Agencies with the federal government funding over $2 million for their health planning and resources development purposes. Additionally, the federal government is funding over $19 million in FY 1977 for the operation of State Health Planning Development Agencies. The federal cost/benefit commitment to continue such activities must be reviewed should the constraints under H. R. 6575 be instituted. Why two such programs, with multiple layers of state/federal bureaucracies under a national capital expenditure ceiling? A more plausible alternative would be for the federal government to fully implement and administer Title XVI of P.L. 93-641 for the related planning and capital expenditure programs. If federal and state agencies cannot administer and implement present statutes, H. R. 6575 cannot be viewed as an instant panacea. In short, P. L. 93-641 and P.L. 92-603 must either be made to work or be repealed.

We fully recognize the problems of excess beds and certainly all efforts to convert, mothball, or close unneeded capacity should be carried out. The positive actions included in legislation recently introduced by Senator Herman Talmadge (S.1470) as well as H. R. 7079, introduced by Representative Paul Rogers, would recognize costs associated with conversion or closure of beds and thereby provide an incentive and assistance to institutions taking such actions.

Another approach which promises to assist in the efficient use of existing capacity in our small, rural hospitals is the inclusion in this same legislation of a provision to facilitate the alternate use of acute-care beds for either long-term or acute care patients through a simplified cost reimbursement method and the elimination of certain regulatory requirements which have effectively precluded such mixed use. We support this proposal which we believe can permit rural hospitals to manage their resources more efficiently, as well as provide a more adequate range of care for the communities served.

We also recognize the desirability of limiting the number of new beds where appropriate and dealing with unnecessary expansion of services and the corresponding duplications. On three occasions since our initial efforts in 1973, our Association has strongly supported state Certificate of Need legislation but each year the General Assembly failed to act on this legislation. As established in April 1977, our State Health Planning Agency is to become operational (conditionally) July 1, 1977.

UTILIZATION/PEER REVIEW MECHANISMS:

One action of a three-part alternative proposal to H. R. 6575, as recommended by the National Council of Community Hospitals (NCCH) in its testimony on May 12, proposed the initiation of "sanctions that would cause physicians to comply with PSRO and Utilization Review strictures on admissions and length of stay."

In strengthening utilization peer review, the NCCH further proposed that:

> A mechanism would be instituted to provide that when a hospital admission or portion of a hospital patient stay is found upon PSRO or utilization review (UR) to be unnecessary, the responsible physician's compensation, from whatever source, would be reduced because of the improper admission or unnecessarily long stay.

Such sanctions must be addressed in any hospital cost containment reforms. Our Association urges that this issue, as proposed by the NCCH, be addressed and instituted by amendments to P.L. 92-603 statutes.

Our member institutions have actively engaged and cooperated in multiple educational and operational UR/peer review efforts. The average length of stay (6.4 days) in Georgia during 1975 was 1.1 days lower than the average for all states in its region and 1.3 days below the national average of 7.7 days.

We propose that equal sanctions for compliance with PSRO and utilization review mechanisms should be addressed as a relevant issue in any future nationwide health reforms.

CONTROLS ON PAYMENTS TO HOSPITALS:

H. R. 7079 and S.1470 deserve serious consideration as a revised payment mechanism with potential application to all classes of payers or purchasers. As a state lacking any prospective payment or rate-setting mechanism, S. 1470 (with its various exception processes at this time) is a viable alternative. While S. 1470 applies only to medicare and medicaid, it should be extended to include all purchasers of care.

S. 1470 would provide for:

- A varied classification of hospitals by bed sizes/functions
- A recognition of area differences in wages, etc.
- A recognition of efficient and inefficient hospitals
- Various incentive projects
- A phased-in testing period.
- The separate recognition of various costs such as capital, energy, insurance, education.

GOVERNMENT REGULATIONS:

Government regulations have significantly contributed to the cost of hospital care. We strongly urge that the government officially establish and operate a "Hospital Regulation Cost Benefit Program" for the specific function to determine and publicize cost benefit analysis for each health related regulation it imposes on hospitals, the tax-paying citizens of this nation, and all purchasers of health-care insurance.

CONTROLLING PATIENT DEMANDS:

Unchecked demand for health services increases costs for care. Patient demand is generally unrestricted by the need to make out-of-pocket payments when services are used.

The proliferation and operation of more federal health programs for more people with federal/state taxation since the 1960's has increased the demands for care on all segments of the health industry. For example, by a recent study the federal government and state, local government agencies acting on its behalf, represents a forty (40) percent "demand factor" on the provision of hospital services by Georgia community hospitals.

The Carter administration has not introduced one bill or amendment to reduce,curtail, suspend, or eliminate the eligibility requirements or health services authorized therein for one current federal health program. Moreover, no changes have been offered in the revision of copayment or deductible cost provisions for any existing health program.

Such a heavy demand factor by the government should bring a strong commitment for cost containment from the government.

In conclusion, our Board of Trustees and our membership as supported in our various meetings, strongly agree that:

- - H. R. 6575 is unsound in concept.

- - It unfairly regulates one segment of the economy.

- - It ignores the reasons for cost increases, the planning process, and the cost saving implementations of existing laws such as P.L. 93-641 and P.L. 92-603.

- - Its complexity is such that implementation would require a huge bureaucracy that in itself would increase health care costs.

- - It virtually eliminates medical progress while leading to a reduction in existing services.

This completes our statement on H. R. 6575.

However, since information was solicited by your Committee on Uniform Functional Accounting Systems proposed in H. R. 3, our Association submits the following statement on this issue.

UNIFORM FUNCTIONAL ACCOUNTING SYSTEMS:

Pursuant to the Committee's announcement of May 6, 1977, and request for testimony on providing authority to the Secretary of Health, Education, and Welfare to promulgate uniform functional accounting systems, we strongly support the following view as submitted by the American Hospital Association:

Section 19, of H. R. 3, as adopted by the Subcommittee on Health and the Environment of the Committee on Interstate and Foreign Commerce, provides for the establishment of a uniform system of reporting by health services institutions. We agree with this objective. But we oppose Section 19 which calls for the establishment of a uniform functional accounting system for health services institutions. We believe that the objective of uniform reporting, including the comparability of financial data, can be achieved without the necessity of establishing a uniform functional accounting system.

Substantial costs would be incurred in converting existing hospital accounting systems to a mandated uniform functional accounting system without demonstration of value in return. The conversion costs on a national basis for hospitals alone have been established at approximately $140 million and additional annual expense could be anticipated by the necessity of maintaining two accounting systems in most hospitals; i.e., one for internal management purposes and one to meet federal requirements. Hospitals should be allowed to "crosswalk" from their management accounting system to the required uniform reports. A "crosswalk" procedure is normal for reports required by the Internal Revenue Service, Securities Exchange Commission, etc. Until such time as it can be demonstrated as necessary and cost efficient, legislative provision for mandating a uniform functional accounting system on hospitals, Section 19 should be deleted from H. R. 3.

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Public Citizen

COMMENTS ON H.R. 6575 AND S. 1391, HOSPITAL COST CONTAINMENT ACT OF 1977, BY PUBLIC CITIZEN HEALTH RESEARCH GROUP TO THE HEALTH SUBCOMMITTEES OF THE SENATE HUMAN RESOURCES COMMITTEE AND THE HOUSE COMMERCE AND WAYS AND MEANS COMMITTEES

MAY 23, 1977

The Public Citizen Health Research Group supports the thrust and many of the specific features of the proposed Hospital Cost Containment Act of 1977. We believe that effective federal regulation of the health care industry in general and hospitals in particular is long overdue. This legislation represents an important first step toward more significant reforms in the structure and financing of health care designed to prevent an industry now wildly out of control from continuing to rob the consumer's pocket while not improving (and often harming) his or her health.

We do have criticisms of and suggestions for improving several provisions in the bill, however:

Title I: Revenue Controls

1. The reimbursement methodology should be modified to encourage savings by providing incentives for efficient hospitals to increase charges less than 9%.

2. The loophole which exempts radiologists, pathologists, and anesthesiologists who bill directly from the revenue limits must be closed. Otherwise much of the anticipated saving will be lost, because expenses for these ancillary services are one of the fastest-increasing components of hospital costs.

3. The size of the financial incentive given to hospitals for closing a service found inappropriate by a State Health Planning and Development Agency should be much more limited.

4. State rate control programs should be exempted only if they can annually demonstrate their effectiveness and ability to prevent patient-dumping.

5. New hospitals should not be exempted from revenue controls.

6. Public disclosure of financial information by hospitals must be extended to conflict-of-interest information on hospital trustees. All information must be posted or readily available at the hospital and disseminated to the press.

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7. The enforcement of the provision to prevent "dumping" of charity patients must be completely revised.

Title II: Capital Expenditure Controls

1. We strongly support a dollar ceiling on capital expenditures by hospitals but oppose the exclusion of Federal and HMO hospitals and of medical equipment in non-hospital settings.

2. The standards for hospital bed supply and occupancy rate should be 3.0 beds per thousand and 85% respectively instead of 4.0 and 80%. This effectively means a national moratorium on increases in the hospital bed supply.

3. The provision allowing half as many new beds to be built as are closed must be eliminated. Only replacement facilities which reduce bed capacity and meet certain other criteria should be allowed.

4. Hospitals must be required to report the data necessary to create a useful national health information system.

Each of these points is discussed in detail below.

We wish to emphasize that our support for this legislation is not only conditioned on the amendments listed above but also premised on the fact that this is only an interim transitional program which will lead to broader reforms. These more significant changes include compensating all physicians by capitation, salary, or strictly-controlled nationally-standardized fee schedule, a massive federal program to promote development of consumer-controlled health maintenance organizations, closure or conversion of excess hospital and technological capacity and development of community-based non-institutional alternatives, and eventual nationwide reimbursement for comprehensive health care on a capitation basis.

TITLE I

1. Providing Incentives for Efficient Hospitals

An ideal reimbursement system would reward particular hospitals which provide a given quantity and quality of services relatively cheaply. Elaborate refinements, however, are difficult to build into a transitional program which must be implemented in a short time period. Any attempt now at "fine-tuning" by, for example, zero-based budgeting might well cost more to implement than it would save.

Long term solutions, on the other hand, should employ financial inducements to encourage hospitals to look carefully at their entire budget and not just at incremental increases. We also would urge future cost control programs to look at community or area-wide expenditures rather than just institutional budgets. The most relevant indicator may be hospital (or all health care) spending per capita rather than cost per admission in a particular hospital (see comments below on data collection).

Section 111(a) of the bill does provide some incentives for hospitals to hold cost increases to less than 9% (assuming that is the ceiling) per year. The revenue increase limit accumulates at the rate of 9% more each year without regard to the actual increase in a particular hospital in previous years. Thus a hospital can increase its average reimbursement per admission by more than 9% in a particular year if the increase in a previous year was less than 9%. For example, a 7% increase in year one could be followed by an 11% increase in year two. This approach does not save payers any money but does create some flexibility for providers. Those hospitals efficient enough to control increases in one year are rewarded by being allowed larger increases in subsequent years.

This method differs only in timing from paying all hospitals 9% increases and allowing them to retain the difference if their actual cost increases are less than 9%. Under that system, hospitals would have cash in hand during the first year rather than having to collect it through higher charges in the second year. It also would not achieve any savings for payers.

Such incentive systems, especially those which allow the hospital to accumulate surplus cash, do not guarantee that the retained funds will be well spent. If the money is used for capital expenditures, the planning process ought to direct spending into closure and conversion of excess capacity. The money could also be used to reduce future charges and/or to increase future spending per patient. The latter is usually not desirable, but completely taking away the hospital's discretion over how the money is spent also removes the incentive.

Either approach could be modified to yield some savings for the payer without destroying the incentive for the hospital to be

efficient. If a hospital increases charges by less than 9%, it could be allowed to keep (or carry over) 50% or 75% of the difference. For example, if a hospital increased reimbursement by only 5%, it would retain or carry over 3% and the other 1% would be saved. This system has some similarity to the provisions in S.1470, which modifies Medicare and Medicaid reimbursement methods.

A comprehensive reimbursement system also ought to include financial rewards for hospitals which have lower costs than other comparable hospitals. One approach is to classify hospitals into several groups, set the reimbursement ceiling at the average for each group, and allow hospitals with below-average costs to retain part of the savings. S. 1470 provides for classification but would set the ceiling 20% above the average.

2. Coverage of Services Provided by Hospital-based Physicians

The most glaring weakness of Title I of the bill is the failure to bring all inpatient services performed by hospital-based physicians under the limit imposed on increases in hospital revenue.

Section 114(a)(1) defines the hospital revenue base as including "revenue from reimbursement due and inpatient charges imposed for inpatient hospital services." "Inpatient hospital services" are defined under section 112(b) by cross reference to the Title XVIII (Medicare) definition. Regulations promulgated thereunder (20 CFR §§405.116(e) and 405.486) provide that diagnostic or therapeutic items or services, such as laboratory tests or radiological procedures, are inpatient hospital services only if the patient is billed for such services by the hospital. If a physician bears part or all of the costs and bills the patient directly, the costs are not part of the hospital budget, are not "inpatient hospital services," and therefore are not subject to the hospital revenue ceiling imposed by the bill.

A substantial percentage of hospital-based pathologists and radiologists and most anesthesiologists now bill patients directly. If this legislation is passed in present form those hospital-based physicians who are not now billing directly will have a powerful incentive to switch to direct billing in order to escape the revenue ceiling. If they do, section 114(a)(2) of the bill will operate to exclude those costs from the hospital's base revenue. However, the hospital-based physician departments will no longer be subject to the revenue controls. These physicians, with the support of the rest of the medical staff, will usually have the bargaining power to switch to direct billing whether or not the hospital administration favors such a change.

Such a loophole will defeat or largely mitigate the effectiveness of the control program. Ancillary services provided to inpatients by hospital-based physicians constitute a significant percentage of all inpatient hospital costs. Even more important,

aggregate expenditures for radiological and laboratory procedures (reflecting both charges for and volume of services) have been increasing faster than other components of hospital expenditures. For example, Senator Kennedy pointed out in introducing this bill that the aggregate cost of laboratory tests had increased from $5.6 billion to $15 billion between 1971 and 1975. Thus the ancillary services component of increases in hospital expenditures is even larger than the ancillary services component of the base budget.

Excluding ancillary services from the revenue limit may in fact cut the anticipated savings from the cost containment program by as much as half (i.e., half of the increase above 9% per year may be attributable to the ancillary services component). In fact, a large part of the need for this program stems from the extraordinary increases in expenditures for lab tests and x-rays.

The language of section 114(a) should be amended to cover all reimbursement for services delivered to hospital inpatients, including all services provided by hospital-based physicians (which would cover all laboratory tests, radiological procedures, anesthesiological services, EEGs, EKGs, etc.) regardless of whether the hospital or physician bills the patient, excluding only surgical fees and physician hospital visit fees.

This approach, however, would create the administrative problem of applying the revenue increase limit to a category of revenue which was not part of the hospital budget in the base year and therefore was not included in the base year Medicare cost report. Payment by or charges to each payer for each ancillary service could be limited to 9% more than their level in the base year, without having data on the aggregate budget for the department. However, applying controls only to fees for each service will create an incentive for radiologists and pathologists to increase the volume of services they render, which they are capable of doing and which would reduce or eliminate any savings.

In order to avoid this problem the revenue increase limit must be applied to total expenditures (as it is for other inpatient hospital services). All reimbursement to hospital-based physicians from all payers for ancillary services rendered to inpatients during the base accounting year would have to be aggregated and added to the hospital's base revenue. Although hospitals or hospital-based physicians should have data on physician-billed ancillary services revenue, it has not been required to be reported in standardized form by Medicare as have hospital-billed inpatient costs.

Therefore, a special one-time report of physician-billed revenue data for the base year would be required in order to include all inpatient ancillary service revenue in the base budget. For future years, the Medicare cost report could be amended to routinely require such reporting. There is already a Medicare cost report form for ancillary services which only asks for hospital-billed charges.

Hospitals could also be required to bill the patient for all charges--eliminating direct billing by physicians.

Even if it is not feasible for physician-billed ancillary services to be covered the first year, there is no administrative obstacle to requiring all hospital-based services to be billed by the hospital, eliminating direct physician billing, as of October 1, 1977. There would be no ceiling during the first year on reimbursement for ancillary services which had previously been physician-billed. Then in fiscal 1979 those services would be subject to controls based on data reported during fiscal 1978. But this approach would encourage hospitals to artificially inflate their fiscal 1978 charges to establish a large base. The fiscal 1978 data would have to be audited based on the fiscal 1977 physician-billed data.

A further reform, which is perhaps beyond the scope of this legislation, would require all hospital-based physicians in hospitals participating in Medicare and Medicaid to be compensated by salary, which would remove the incentive to maximize volume of services associated with either a fee-for-service or percentage-of-gross-charge payment system.

3. Services Eliminated from Hospital Budget After Being Found Inappropriate by State Planning Agency

Section 114(b) of the bill would exclude from the hospital's base revenue the cost of any service which is closed or otherwise removed from the inpatient hospital budget, for example, an OB unit. Otherwise, the hospital would be able to reap windfall profits by closing a service--costs would decrease but revenues would not. However, if the service is eliminated after being found inappropriate by a State Health Planning and Development Agency, the associated costs are not excluded from base revenue and the hospital is allowed to profit. This exception is intended to encourage hospitals voluntarily to close or change to an outpatient setting an inappropriately utilized service in accordance with the findings of the planning agency where the state has not forced closure.

We support the use of financial incentives to encourage compliance with state and local planning decisions. However, this incentive is so large that it defeats the primary purpose of periodic appropriateness review under the planning program--cost containment. If the public is required to continue to pay for excess capacity which is eliminated, no money will be saved. We recommend that this language be amended to limit the exception to one year and to not more than 5% of the hospital's total budget.

An alternative more appropriate to the objective of encouraging reduction of excess capacity would be to continue to pay the hospital for any capital costs associated with closing or converting the service. For example, if a hospital with low occupancy closes a wing containing 25% of its beds, it would be allowed to continue to include 25% of the debt service on the structure but not any of the operating or maintenance costs--unless and until it was converted to provide needed lower intensity services such as long term care which have received planning approval.

4. Exception for Changes in Services Which Increase Inpatient Costs per Admission

Section 115 allows for exceptions to the revenue increase limits under certain circumstances. Section 115(a)(1)(B) covers changes in capacity or in the character of inpatient services which increase inpatient costs per admission by more than 3% (assuming the revenue limit is 9%) over the previous year. Since inpatient costs per admission will almost certainly be increasing more than 3% per year without any such changes because of inflation alone, this requirement will always be met. The 3% requirement should either be eliminated or raised to 9% (by deleting "one-third of"). In any case, the hospital must also satisfy the solvency and planning criteria of paragraphs (2) and (3) before an exception may be granted.

5. Exemptions for State Programs

Section 117 would allow the Secretary to exclude from federally-administered reimbursement controls state rate review programs which meet certain conditions. We believe it is appropriate to allow states to operate their own programs so long as they effectively contain aggregate revenue increases within the federally-established limit, as provided in section 117(3). However, section 117 must be amended to require strict annual publicly-disclosed reviews of each excluded state, and the exemption must be revoked if revenue increases exceed the limit.

Also, the anti-patient dumping requirement of section 126 (as amended as suggested below) must be enforced in every hospital whether under federal or state controls. We urge that section 117 be amended to explicitly require the state to certify that section 126 will be enforced under their program. Data demonstrating such enforcement must be submitted annually to the Secretary and made publicly available.

6. Exemption for New Hospitals

Section 121(b) of the bill excludes from the definition of hospital for purposes of reimbursement controls any hospital which is less than two years old. Apparently the rationale for this approach is that no historical cost data is available on new facilities. However, the exemption will create an additional incentive for new hospitals to maximize their initial charges. When they come under control after one or two years their base budget will be so inflated that revenue controls will not force them to be really efficient.

An initial revenue base could be established by reference to similar hospitals. An alternative would be to perform a complete audit of all new hospitals when they first come under control to assure that initial charges were not artificially inflated. It is also not clear under the present language whether new "satellite" facilities of existing hospitals would be excluded or included.

7. Public Disclosure of Financial Information by Hospitals.

Under section 125, disclosure is being limited to charges for ten services selected by the area HSA and medicare and other third-party payer cost reports. How and where this information will be available to the public is not clear. This scope of disclosure is grossly inadequate. We urge that you require disclosure of the following:

(1) The legislation should explicitly provide that all data of any kind reported to HEW or a state agency under this program, specifically including the Medicare cost report, is available to the public at the hospital or from the

government on request. Such language would avoid subsequent controversy as to whether the data is publicly available under the Freedom of Information Act.

(2) The hospital charge data should be expanded and made more easily accessible to the public. Having the HSA select and define the services in each area guarantees that inter-area comparisons will be impossible. The Secretary should be required to develop a list of at least 30 of the most common and/or most expensive hospital services including room and board, operating room, delivery room, intensive and coronary care units, lab tests, radiological procedures, anesthesia, outpatient or emergency room visit, drugs, special therapies, etc.

For each health service area, the HSA should develop a large table or printout showing each current charge for each hospital in the area as well as for the previous 3 six-month periods. These charts should be required to be posted in a prominent place (e.g. the admitting desk) in every hospital and should be distributed to the press every six months.

This approach would heighten public awareness of the cost problem, allow inter-hospital price comparisons, and strengthen enforcement of revenue controls through self-policing.

(3) The requirement of disclosure of information about the relationships between members of the hospital governing board and firms which deal with the hospital was apparently dropped at the request of OMB. This is puzzling since such requirements are certainly not costly and are already part of state programs such as the Maryland hospital cost review commission.

All substantial ownership, fiduciary, employment, or consulting relationships between any trustee or hospital administrator and any firm supplying goods or services to the hospital or which is a creditor of the hospital should be disclosed on forms which are posted or available at each hospital and distributed to the press annually.

The existence of conflicts of interest may have a substantial cost impact on the hospital, though such is not always the case. In any event, the public is entitled to full accountability from hospital trustees--who ostensibly are representatives of the community.

(4) Salaries of all senior administrative employees of the hospital (perhaps the 2% of all employees with the highest salaries plus anyone else earning more than $30,000 per year) such as the hospital administrator and department heads should be posted at each hospital and distributed to the press (just as the salaries of state employees are published in many states).

(5) The net income of all hospital-based physicians (radiologists, anesthesiologists, etc.) whether they are employees of or contractors with the hospital or merely provide services to hospital patients should be publicly available at the hospital.

8. Preventing "Dumping" of Charity Patients

It is immediately apparent to anyone familiar with the history of nearly universal non-enforcement of the "free care" requirements of the Hill-Burton hospital construction act that section 126 of the bill is grossly inadequate. Developing an anti-dumping enforcement mechanism which can be implemented effectively in the short term, however, is problematical.

Presumably, patients "for whom reimbursement at less than the inpatient charges. . .applicable to such inpatients is anticipated" in section 126 includes only those who are charged nothing or less than full charges because of inability to pay and excludes bad debts. Whereas now hospitals can, if they choose, subsidize such charity patients by charging more to other patients (at least to charge payers), with the revenue cap their ability to so shift costs will be restricted. The financial pressure to minimize the difference between gross revenue, which is directly controlled by the cap, and net revenue, which is not, by turning away all charity patients and likely bad debts is increased.

The largest obstacle to enforcing a "maintenance of effort" requirement is the lack of baseline data. The Medicare cost report does not distinguish between bad debts and charity care. Hill-Burton compliance data has never been collected in most states. The first step in any enforcement program must therefore be the reporting of data on the amount of charity care provided during fiscal 1977. This could be done as a supplement to the Medicare cost report and/or on a compliance report to the Hill-Burton state agency. Using the same data for both the maintenance of effort requirement and Hill-Burton might prevent deliberate under-reporting.

Beginning October 1, 1977, hospitals should be required to report the number of charity patients served monthly. Both the baseline and the monthly reports should be fully disclosed to the public. Any person, not just hospitals, should be allowed to complain. The monthly reports should enable the HSA to screen out spurious complaints.

The sanction in section 126, exclusion from participation in Medicare and Medicaid, will almost certainly never be imposed by HEW because it would force closure of the hospital. The penalty should either be financial—loss of revenue for reduction in charity care--or denial of all certificates of need until the hospital is in compliance. Legal rights of action also could be created. Mechanisms for enforcement and sanctions are more fully discussed in the statements of the National Health Law Program and the Center for Law and Social Policy.

TITLE II

1. Capital Expenditure Ceiling

We support section 201(a), which, by addition of section 1504(a) to the Planning Act, imposes a dollar limitation on hospital capital expenditures and sets it below the amount which has been spent in previous years. Past expenditures have included substantial sums for new hospital construction and equipment which was duplicative and unnecessary. Future spending must be redirected toward maintaining existing physical plants to assure worker and patient safety and conversion of existing facilities to more appropriate uses, especially outpatient, non-institutional, and emergency care. It seems likely that $2.5 billion a year is sufficient for these purposes, though there is not enough data available to make precise calculations.

2. Exceptions to Capital Expenditure Ceiling

The expenditures ceiling apparently applies to all capital expenditures or lease arrangements made by short-term hospitals (including those related only to outpatient services) which meet the definition added by section 201(c) to section 1531 of the Planning Act. Federal and HMO hospitals are excluded. Although such facilities arguably should be exempted from reimbursement controls because of existing budget constraints, there is no parallel reason for their exclusion from capital expenditures controls. General hospital planning criteria must apply to all hospitals because of the impact of capacity changes at one hospital on the cost and pattern of patient care at other facilities in the same service area. Treating federal hospitals (which have about 10% of all medical-surgical beds in the U.S.) and HMO hospitals as if they were independent of the rest of the health care system is bad planning. Therefore, we urge that capital expenditure controls apply equally to all short-term hospitals regardless of ownership.

Limiting the coverage of the ceiling to hospital purchases will also create incentives for providers to make capital expenditures in non-hospital settings. For some types of projects, such as free-standing long term care and primary care facilities, such incentives may often be appropriate.

However, in the crucial area of high technology medical equipment such as CAT scanners, the exclusion of non-hospital purchases

is a fatal and costly loophole. Planners trying to control the unnecessary proliferation of CAT scanners are already hampered in most states by lack of legal authority over purchases by private physicians whose hospitals have been denied certificates of need. The ceiling will exacerbate the problem by making it more difficult for hospitals to buy scanners without covering physicians. We strongly urge that the ceiling apply to the purchase or lease of all medical equipment costing more than $100,000 regardless of purchaser or setting.

3. Ceilings for the Supply of Hospital Beds and Standards for Occupancy of Hospital Beds

We strongly endorse the statutory establishment in section 201(a) of national standards for the short-term hospital bed supply and for occupancy rates by the addition of section 1504(b) to the Planning Act. We have included such criteria in our Model State Health Planning and Certificate of Need Statute. However, we urge that the bed ceiling be set at 3.0 rather than 4.0 short-term hospital beds per thousand population and that the occupancy standard be set at 85% instead of 80%. Attached as an appendix to these comments are excerpts from the Model Statute mentioned above which contain arguments supporting these criteria.

This language does not require hospitals in any area with excess beds to close all the extra beds immediately. It only means that any area which is at or above 3.0 beds per thousand population can not increase the number of beds. The research on hospital bed supply suggests that the optimal bed ratio is actually much lower than 4.0 beds per thousand. In fact, it is probably also below 3.0 per 1000. Reducing the bed supply to 4.0 per thousand may be a realistic short term goal. However, it would be counter-productive to allow areas which now have fewer than 4.0 beds per thousand to increase to that level only to decide a decade from now that those beds are also unnecessary and must be closed. There may not be any areas in the U.S. which now meet the 3.0/85% standard. Thus we are effectively proposing a national moratorium on new bed construction until there are substantial increases in population.

Closure and conversion of excess capacity must be commenced immediately but the details of which facilities should be required to reduce how much capacity over what time period must be worked out at the state and local level.

Under section 1504(b)(2) the Secretary is allowed to set different standards for areas "which have special characteristics or meet special requirements established by the Secretary." We strongly urge that the Secretary not be allowed to set a higher bed ceiling (especially if the statutory standard is 4.0 beds per 1000) unless there is substantial net in-migration of patients from outside the area. Even in such circumstances the ratio of beds to population served should not change. Rather the population base should be increased to reflect the out-of-area patients served.

4. Exceptions to Supply Ceiling and Occupancy Standard

Our recommendation discussed above that Federal hospitals and HMO hospitals be subject to the capital expenditure controls also applies to the bed supply and occupancy rate standards.

Section 201(b)(1) of the bill would amend section 1527 of the Planning Act to prohibit the granting of certificates of need for new hospital construction in areas which already have or as a result of such building would have more than 4 beds per thousand population or less than an 80% average occupancy rate. (As discussed above, we believe these standards should be 3 and 85%, respectively.) However, the bill in section 1527(b)(2) and (c)(2) allows an exception in areas with excess beds or underutilized hospitals. One new bed may be constructed for every two beds which are taken permanently out of service. The new beds may be built in a different location or in a different year.

This exception must either be deleted or very narrowly limited. As it stands, it may encourage a socially undesirable trend which has already begun. Large urban hospitals with old physical plants located in declining inner city areas whose medical staff members are moving their offices to more affluent suburban areas are anxious to close down their central city facilities and build in the suburbs, leaving behind the poor and minority patients they previously served. Lawsuits seeking to block such relocations are pending in Gary, Indiana and Wilmington, Delaware. Requiring reduction of bed capacity by 50% may not be a large disincentive when the occupancy rate in the central city facility was already low. Nor can there by any justification for closing a 400 bed hospital in an overbedded city in order to build a 200 bed hospital in another even more overbedded city in the same health service area.

We recommend first that section 1527(b)(1) be amended to clarify that certificates of need may not be granted for any project which would increase the total number of hospital beds in an area if the bed supply, either before or as a result of the project, exceeds the ceiling. Second, the section 1527(b)(2) "two for one" language should be replaced by this language after ". . .then a certificate of need may be granted for": a replacement facility but only if such facility substantially reduces licensed bed capacity, is constructed at or near the site of the facility being replaced, and is less expensive than the renovation or modernization of the existing facility, if any, required to maintain compliance with licensure, accreditation and safety code standards.

5. Data Needed for Regulating the Health Care System

In order to make rational decisions about reforming the organization, financing, and delivery of health care, we first must know exactly how the health care dollar is now being spent and for what services, and how such expenditures and services vary geographically. Currently there is only a limited amount of such information, and

what is available is often not comparable among areas or programs.

Three important elements of a meaningful data system are often missing.

(1) Data, especially financial data, is often collected and presented on an institutional rather than an aggregate basis. Aggregate information is needed in order to reflect both the expenditures per institution and the concentration of institutions in an area.

(2) Data is often not related to population. When the supply of general hospital beds was expressed per thousand population, the fact that some areas have much higher ratios than others led to calls for reducing the bed supply. Per capita rates for all other measures of utilization, resources, and expenditures should also be calculated.

(3) These population-based indicators should be developed by small geographic area. Nationwide figures tell us nothing about geographic differences and even statewide figures can conceal more than they reveal. Rates should be calculated by health service area and by standard metropolitan statistical area and perhaps also by smaller service areas within an HSA or SMSA, to the extent they can be identified.

Significant differences among geographic areas in, for example, hospital expenditures per capita, should be a red flag that there are excesses in the high areas. At that point, adjustments must be made to the crude data to make it more comparable among areas. Differences in cost of living and distribution of patients by primary diagnosis, age, sex, race, and income should be taken into account. Also, the population base must be adjusted to reflect in- and out-migration of patients. If these adjustments don't explain the geographic differences, then, in the absence of evidence that the low figures for utilization and expenditures indicate deficiencies which have an adverse effect on health, regulatory actions directed at the areas of excess expenditure should be mandatory.

There are a host of variables for which per capita rates ought to be calculated. Rates for some variables are already available at the national level and in some geographic areas, for example: beds, hospital patient days, physicians, hospital discharges, surgical procedures, and average length of stay. But there is much less data at the regional and local level and much data which would be useful isn't collected or isn't calculated per capita on the local level, for example: hospital assets, total hospital expenditures, hospital employees, long term care expenditures, etc.

This list could be greatly expanded by additional categories or sub-categories. However, the information falls into two broad categories, at least for financial data. The first is the mix, volume, and price or charge of services delivered--payments to

providers. The second is payments made by providers for the goods and services they purchase in order to deliver services: payroll costs, energy costs, administrative costs, cost of supplies, etc.

In addition to identifying geographic differences, this kind of data system could be used to monitor differences in utilization and expenditures by type of payer--pre-paid v. fee-for-service--and by particular source of payment--Blue Cross v. Medicare v. Medicaid v. commercial insurers. Such comparison has been done only in research studies in the past.

Implementing a comprehensive health care data system will be a massive task. Some of the data, such as hospital assets, employees, and expenses, already is being reported on an institutional basis in the AHA annual survey. However, none of the area data is calculated per capita.

In order to make valid comparisons for medical, utilization, and expenditure data, all the important variables mentioned above relating to the cost and nature of services must be linked to the characteristics of patients. Because sampling is insufficient to make valid comparisons among small categories of patients or among small geographic areas, the key items must be collected on every patient in every hospital all the time. Also, every reporting institution must define and categorize these items in the same way. Finally, there must be some assurance that the data is being accurately maintained and reported from the source patient and financial records.

There are currently a multitude of health data systems operating at the federal, state, and local level which collect some of the relevant data in some areas. These include the American Hospital Association survey of hospitals, the PSRO program, the Medicare 20% sample of discharges, the Medicaid Management Information System, the National Center for Health Statistics sample survey, the Professional Activity Study and other similar hospital patient data systems, some Blue Cross plans, and some data collection activities of state health departments and local planning agencies. There has been some effort to standardize and tie these systems together through the Uniform Hospital Discharge Data Set and the Cooperative Health Statistics System of NCHS. However, few if any geographic areas have 100% standardized reporting on all hospital patients, for example. Cost data usually can not be linked to characteristics of patients. Even when data has been collected, it often is not presented in a format which is easily understandable and which facilitates comparisons and often is not made widely available to politicians, the public, and the mass media. For example, per capita statistics by health service area for such variables as surgery, hospital patient days, hospital expenses, general hospital beds, hospital assets, hospital employees, and average length of stay should be developed and broadly disseminated to form a basis for analyzing proposals to reform health care delivery.

For these reasons, we urge that this legislation provide the impetus for the hospital component of a national health data system by requiring every hospital subject to controls to report a standardized set of data items on every patient to an existing data system which makes it available to PSROs, HSAs, state agencies, HEW, the press, and the public generally. To protect patient privacy, no information which identifies a patient should be reported outside the hospital. Formulating permanent reforms in health care delivery and organization will be difficult if not impossible in the absence of such a meaningful health data system.

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APPENDIX

Bed Ceiling and Occupancy Rate
(Excerpt from Model State Health Planning and
Certificate of Need Statute)

(a) We think it is essential that the SHP establish a ceiling on the number of short-term, acute care hospital beds in the State. Short-term, acute care is defined in section 102(w). We have suggested a maximum of 3.0 short-term beds (including federal beds) per thousand population. The goal of 4.0 beds per 1000 (not including federal beds) has been endorsed by HEW in the proposed national guidelines, by the National Academy of Sciences Institute of Medicine, by another HEW-funded study conducted by InterStudy, and already has been adopted by the state of Massachusetts. A ceiling is also supported by the Health Research Group's 1975 book The Eight Billion Dollar Hospital Bed Overrun.

All of these sources suggest that even though achieving this goal would require more than a 10% reduction in the total bed supply (now at 4.5 beds per thousand), 4.0 beds/1000 is too high and should be followed by further reductions. HEW says that "populations have been adequately served by 2.5 beds per 1,000 or even less.

Health maintenance organizations hospitalize their under-65 members at a rate of about 500 patient days per 1000 (some have rates less than 400) compared to about 900 for the entire population. HMO rates for those over 65 are about 2500 patient days per 1000 (some have rates less than 2000) compared to about 4100 for the entire population. There is no evidence that the lower HMO hospitalization rate has in any way impaired the health of HMO members. Combining these two typical HMO rates and weighting for the age distribution of the U.S. population yields a population rate of about 700 patient days per thousand compared to the current 1200 plus for the entire population.

Assuming a rate of 700 and an occupancy rate of 85% (the conventional assumption for efficient hospital operation); (the current national average occupancy is about 75%) only 2.3 beds per thousand population would be needed. Thus, there

is ample support for setting a bed ceiling at or below 3.0 beds per thousand.

This conclusion is also supported by data presented in the recent InterStudy report mentioned above.* Virtually all of the arguments we make in the following comments are supported by evidence and analysis presented in that study (footnoted at appropriate points in the commentary), which also provides much more complete discussion of all the problems associated with reducing excess hospital capacity.

Writing a quantitative bed ceiling into a state CN law is unprecedented and will be bitterly opposed by providers, especially hospital groups. In virtually every state such a ceiling will be a statutory declaration that the state is overbedded. Hospitals will make several "counterarguments" and you must be able to deal with them.

(1) "Beds in tertiary care centers which serve people outside the state or outside the health service area should not be counted." The answer to this argument is in the statutory language itself. The population base used to calculate the rate must be adjusted for in- and out-migration of patients. Planners need what is called "patient origin" or "patient destination" data to do this. If 10% of State X's hospital patients are hospitalized in your state, then 10% of X's population should be added to your state's population base. But remember that some of your state's patients receive care in other states and must be subtracted from the population base. Unless there is a net in-migration to your state, this argument has no validity at all.

(2) "The fact that some population groups need more hospitalization than others justifies more than 3.0 beds per thousand in some areas." This argument has some limited validity. Hospitilization rates do vary greatly by age group. For example, people over 65 experience about 17 times as many hospital days per capita as do those aged 5 to 14. Therefore, hospitalization data should always be "age-adjusted". This means that the optimal amount of hospitalization varies with the age distribution of the population--the "older" the population the greater the need for hospitalization. Age adjustment may require a minor change in the bed ratio written into the statute. 3.0 beds per 1000 assumes that the state's age distribution is the same as the national distribution. Have the age-adjusted data to defend whatever bed ceiling ratio you choose.

(3) "Sparsely populated rural areas need more hospital beds because of longer distances between population centers."

First, it is clear that a person does not have a greater need to be hospitalized because he lives in a rural area

*W. Mc Clure, "Reducing Excess Hospital Capacity" 22-27 (InterStudy, Oct. 15, 1976).

rather than an urban area. If there are urban-rural differences in age composition, they should be taken into account by age-adjustment as discussed under (2) above.

The argument is rather that hospitals in areas of low population density need a bigger bed "cushion", i.e., their optimal occupancy rate is lower than 85%, and therefore more beds per thousand are justified.

Having such a bed cushion is necessary to protect patients' health only for critical emergency care. In fact, most patients--75% to 90%, depending on how emergency is defined--are hospitalized on an elective basis, i.e., waiting to be hospitalized will not impair their health. Not having an empty bed immediately available for an elective patient is therefore not a health problem but merely an inconvenience. Such patients can either wait until an empty bed is available or be transported to a hospital which now has empty beds.

If there is no hospital in the community, third party payors should pay for such transportation. If there is only one hospital, elective patients can wait to be admitted (waiting time can be minimized by effective admissions scheduling) or bear the cost of traveling to another hospital. If there are multiple hospitals in the community, the elective patient can either wait for care or seek out an empty bed in an alternative facility. The latter is usually allowed only in those hospitals where the attending physician has admitting privileges. (Urging all hospitals in a community to give admitting privileges to all area physicians should perhaps be undertaken by health planners). In brief, in light of the high cost of maintaining unnecessary hospital capacity, we should tolerate some temporary turning away of elective patients.

For the small minority of patients who are hospitalized for emergency reasons (which should be limited to those who are non-transportable and/or whose health will be impaired by delays in care of only minutes or hours), there may be a need for a larger bed cushion. However, even for emergency care, turning patients away can be tolerated in a multiple hospital area so long as another hospital has an empty bed and there are no transportation or staff-privilege barriers (both of which can be reduced or eliminated by good planning) to getting the patient to the empty bed. Therefore, the only circumstance in which the extra beds are needed for health reasons is for the small percentage of emergency patients in the small minority of all hospitals in rural areas so isolated that the patient can not be taken to another hospital in time. There are few areas in which such circumstances will have a significant effect on the need for hospital beds.

One other variable which makes some difference in the size of bed cushion needed is overall hospital size. Everything else (e.g., the patient "turnaway" rate) being equal, a larger

hospital can maintain a higher occupancy rate because fluctuations in demand are a smaller percentage of total beds in a larger hospital. This effect is documented by Mc Clure.* However, the difference is relatively unimportant in a multiple-hospital area where patients turned away from a small hospital can go to an alternate facility. Also, the larger percentage fluctuations in small hospitals can be reduced or eliminated by well-planned scheduling and, if necessary, by making elective patients wait to be hospitalized.

In summary, except for the small number of extra beds needed to provide adequate emergency care in sparsely populated rural areas, this argument has no validity. We can not afford the exorbitant cost of maintaining unnecessary hospital beds in every small rural area merely for the convenience of elective patients.

(4) "Not all short-term beds are equal. It is meaningless to establish an overall bed ceiling without specifying the type of bed."

In section 102(w) "short-term acute care beds" is defined to include all hospital beds except those providing skilled nursing, intermediate, custodial, psychiatric, and newborn care. The bed ceiling in the statute thus applies to all medical, surgical pediatric, and obstetrics--gynecology beds. The first three categories are not distinguishable in many small hospitals, i.e., one bed may be used for any of the three at different times, and therefore it is appropriate to combine them for purposes of establishing a bed ceiling. It may be preferable to separate OB-GYN and pediatrics from the other categories because the need for such beds depends on factors, such as the number of women of child-bearing age and birth rates, which the others do not. However, there is evidence that even these beds can safely be used for other types of patients.**

In short, planners should break down bed ceilings by type of service and level of care (secondary v. tertiary) where appropriate but that does not mean an overall statutory ceiling is inappropriate. Ceilings or goals should also be established for other categories of beds such as those for psychiatric, skilled nursing, and intermediate care. We have not done so here because of a lack of data and research by our group and by others.

(5) "Some areas in the state may be overbedded and some underbedded. An overall ceiling does not account for differences

* Mc Clure, op. cit., at 17-19.
** Mc Clure, op. cit., at 14.

among areas".

The language in the Model Statute requires a breakdown by health service area, by county, and by SMSA. The only reason why any of these subareas could possibly need more than 3.0 beds per 1000 (after appropriate adjustments of the population base) is because of an unusually "old" population, as discussed under number (2) above. Because 3.0 is a generous goal, only large differences in the age distribution would justify setting a higher ceiling.

Note that 3.0 beds per 1000 is a maximum, not a minimum and subarea limits can and should be set lower. According to 1974 statistics compiled by HEW, eight health service areas have fewer than 3.0 beds per 1000 (some of these may be attributed to failure to adjust the population base). The statutory limit does not mean that such areas need more short-term beds. Only if there are people who actually need short-term care who cannot be accomodated in existing fully and efficiently-utilized facilities is there a need for more beds. And it is almost always cheaper to pay for transportation of elective patients to a hospital with empty beds than to build new beds. As mentioned, the optimal ratio may be in the range of 2.0 to 2.5 rather than 3.0.

(6) "More beds can be justified, even if the area is already at or above 3.0 beds per 1000, if occupancy rates are high and there is a lack of alternative facilities such as long-term or home care."

HEW has compiled statistics on occupancy rates for short-term general hospitals by health service area. In 1974, out of about 200 health service areas in the U.S., only four areas--about 2%--had occupancy rates of 85% or greater. Two of the four had 85%, one had 86%, and one had 91%. A somewhat higher percentage of all short-term general hospitals would have occupancy rates of 85% or more, but there are very few, if any areas where more beds are needed even if one assumes that an 85% occupancy rate justifies more beds. However, 85% is not a maximum. Efficiently operated hospitals can and do take patients up to 90 or even 95% of capacity.

Even if a few isolated communities are experiencing or will experience occupancy rates that high, more beds are not necessarily needed. As discussed at length in The Eight Billion Dollar Hospital Bed Overrun and in the InterStudy Report*, most if not all hospitals are now caring for some patients who don't need to be hospitalized. Some are there for unnecessary surgery, others could more cheaply and appropriately be cared for in long-term care facilities, home care programs, or even on an outpatient basis. Still others need some hospitalization but

*Mc Clure, op. cit., at 22-29.

stay too long. Methods of eliminating medically unnecessary hospital utilization are listed in section 303(c)(2)(B)(i). HMOs have cut rates of hospitalization in half by employing such approaches. It is also worth noting that utilization control programs in the fee-for-service sector have been most successful where occupancy rates are high and physicians are forced to limit hospitalization to those patients who actually need it.

The second argument is that some patients are hospitilized not because there is medical necessity for acute care services but because there are no alternative, lower level facilities available. It should be clear that the lack of alternative services never justifies increasing the number of short-term hospital beds. The alternative services should be developed instead. In an overbedded area unavailability of such services may mean that the excess acute care beds should be converted to a lower level (intermediate care, etc.) rather than closed or that closure should be delayed until alternative facilities are available. But having a short-term bed ceiling would not create hardship in such a situation. In fact in enforcing its periodic review findings, the state is prohibited from taking any action which will have an adverse effect on the availability of necessary services by the proviso in section 203(f)(3)(B).

(7) "Concentrating on the number of short-term beds is conterproductive because it ignores the substantial part of hospital costs represented by equipment and ancillary services. Reducing the mumber of beds will not save money but only increase costs per bed and costs per patient day."

It is surely true that planning which is concerned only with the number of hospital beds and ignores other resources and services is inadequate. This is why Mc Clure uses the term "hospital capacity" rather than "hospital beds".* Establishing a statutory maximum bed ratio does not mean that other services can or should be neglected. Health planners must gather and analyze the data needed to establish such ratios for other services. Indeed, the rest of this section and of the Model Statute requires or suggests that the SHPDA do just that in developing plans and criteria for CN and periodic review. Unnecessary medical equipment, such as CAT scanners, and unnecessary specialized services must be just as vigorously opposed as unnecessary hospital beds.

It is claimed that costs per bed and costs per patient day will increase if the number of beds is reduced, thus offsetting anticipated savings. It is true that not allowing a hospital

*Mc Clure, op. cit., at 11-14. Mc Clure argues that planners should measure the impact of hospital planning by its effect on total hospital expenditures per capita.

to use a few excess beds will not save any money unless there are concomitant reductions in staffing and other costs such as utilities. Clearly, more cost savings per bed will be achieved if an entire wing is closed and even more if an entire hospital is closed.

Closing only a portion of a hospital (i.e., 25%) will not produce savings proportional to the percentage decrease in beds because there are fixed costs such as depreciation, debt service, and the cost of specialized services and equipment which must then be spread over fewer beds.* However, total costs will decrease and, unless the number of patients decreases more than total costs, the cost per patient day will also go down, not up. In any event, any opportunity to reduce total health care costs should be aggressively pursued so long as there is no adverse impact on health, even if unit costs per bed or costs per patient day increase.

In short, the fact that limiting the number of short-term hospital beds is not the only function of health planning doesn't mean it shouldn't be done.

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June 2, 1977

Dear Chairman Kennedy:

With this letter we submit the statement of the Hospital Association of New York State concerning S.1391.

We shall be looking forward to working with your staff in addressing this critical social problem of escalating health care costs. It is essential that in working toward an equitable resolution of the problem we do not destroy a health care delivery system that has brought to the American people the epitome of health care.

Thanking you and the Committee for this opportunity to submit our thoughts, and with the pleasure of our continued assistance in the resolution of the problem, I am

Sincerely yours,

James H. Fitzpatrick.

Rev. Msgr. James H. Fitzpatrick
Senior Vice President

Honorable Edward M. Kennedy, Chairman
Subcommittee on Health & Scientific Research
of the Committee on Human Resources
United States Senate
Washington, D. C. 20510

Enclosures

STATEMENT OF

HOSPITAL ASSOCIATION OF NEW YORK STATE

ON

S.1391

"HOSPITAL COST CONTAINMENT ACT OF 1977"

TO

UNITED STATES SENATE

SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH
COMMITTEE ON HUMAN RESOURCES

May 26, 1977

This testimony is submitted by the Hospital Association of New York State on behalf of its members, 300 voluntary and public non-profit hospitals and health care institutions. These institutions represent about 90% of the general, acute care hospital admissions in New York State, and approximately 10% of those for the entire United States.

In New York State, hospitals are not unfamiliar with reimbursement control. A strict program implementing these controls was enacted legislatively in 1969. In addition, the New York State government has been operating under extreme budget constraints for the past two years, constraints which have impacted directly on reimbursement to all of our hospitals, leaving many of them in extremely difficult financial situations. In spite of these problems New York State hospitals feel that a 15% increase in hospital costs per year is excessive and will support appropriate legislation to slow this increase.

In this testimony we will briefly describe some of the reasons why the cost of health care is increasing so rapidly, and show why we do not believe that S.1391, the "Hospital Cost Containment Act of 1977", is the best method of solving this problem. Our hospitals feel that the proper solution must be centered around a joint effort involving the public, government, and hospitals, and after describing the specific situation in New York State we will suggest alternate solutions to the problem of increasing hospital costs.

SOME OF THE REASONS FOR INCREASING HEALTH CARE COSTS

Medical Advances and the Cost of Technology

We believe that the advances in medical care services have outstripped their costs. Heart attack victims who may have had no chance to live twenty years ago are today regularly being sent home within a month from the day they were admitted. Incidents of tuberculosis and poliomyelitis have undergone dramatic decreases in occurrence. Other diseases which have been checked in the last twenty years include: whooping cough, diptheria, measles, malaria, and typhoid. Cost of stay figures, because of the vacillating length of stay caused by medical advances such as those above, are often rendered questionable. As care improves, the length of stay in certain instances does not necessarily decrease, as evidenced by the heart attack victim. As the length of stay for a procedure or disease decreases, and allows patients to be cared for as outpatients rather than inpatients, the length of stay "progress" which was made becomes void.

Discoveries in the medical field, financed by research funds, have made household words of techniques and equipment which were visions twenty years ago. Organ transplants and kidney dialysis are prime examples of this phenomenon, as is the development of instruments to enable surgery to be performed under a microscope. Unfortunately, these advances are not without concommitant cost increases.

Equipment cost is a prime example. An open heart surgery unit costs $200,000, about the same as a radiation cancer treatment unit, while an intensive care unit costs approximately $500,000.

To put this technological advance in perspective, the cost involved with the following advances must be considered.

Percentage of hospitals with:	1960	1973
intensive care units	10%	71%
open heart surgery units	-	9%
postoperative recovery rooms	52%	80%
inhalation therapy	-	71%

Along with high equipment costs, the hospital staff must undergo an increase in size and level of training to properly operate and care for these specialized units. Respiratory therapist, surgical technician, and nuclear medicine technologist are new positions which technology has brought into hospitals, and training for staff to fill positions such as these, often mandated by law, is necessarily complex and expensive.

When General Motors engineers incorporate automatic welding machines into the assembly line, there is a commensurate decrease in manpower required to accomplish the welding task. In the health care field, economic or "business" decisions are not that simple. Five years ago, after costing out the number of years it would have

taken for an X-ray machine to generate a profit, it may have made economic sense to buy a new one to replace an aging model. Now, with the introduction of whole body scanners, an institution may find a greatly reduced demand for X-ray equipment. Whole body scanners will require new and highly skilled staff to operate them, but they may reduce the need for much exploratory surgery, making them a sound economic purchase in some cases. But not all cost increases can be as easily measured as those caused by new equipment.

Labor

It is important to note that, since the hospital industry is acutely labor intensive, increases in labor costs create increases in the overall cost of health care to a far greater extent than in other industry. Hospitals are roughly twice as labor intensive as most industries. Since the average cost of payroll and fringes in the New York City area is 70% of expenses, a 12% increase in wages would add 7.4% to the cost of running a New York City hospital and only 3.6% to the cost of running an average industrial plant. Problems of this nature must be recognized and properly dealt with by government and regulatory bodies.

Market Basket

The hospital's market basket differs from that of other industries. Malpractice insurance costs for some New York State hospitals have increased by 1500% during the past year, and 300% increases are the

norm rather than the exception. Although not as dramatic, the costs of general liability insurance, the No. 6 fuel oil and natural gas our hospitals use for heat, and construction costs have skyrocketed since 1970. These are examples of exogenous costs over which hospitals have little or no control.

Defensive Medicine

In conjunction with the malpractice problem, many sources claim that physicians are now practicing "defensive" medicine; in other words, ordering tests other than those specifically needed and taking precautions not really necessary -- all because their liability has gone up to such a point where they cannot afford not to take those precautions. This practice contributes directly to the increased cost of health care, but is caused by the present legal position of physicians and hospitals with regard to malpractice suits, and no relief is in sight.

Physician Pressure

Physicians naturally want to treat their patients with the best possible equipment in the best possible facilities. This places tremendous pressure upon hospital administrators attempting to control costs. A recent statement by the Director of the Department of Health, Education and Welfare's National Center for Health Statistics indicates that in the six years between 1969 and 1975, a 2% per year decrease in death rates occurred. The age-adjusted death rate reached an all time low of 6.4 deaths for 1,000 population

in 1975.* Therefore, it is possible that this physician pressure has had positive results; however, it still must be taken into account when considering the increase in hospital costs.

Aging Population

Although the health care field has no direct control over the demographically aging population, that portion of the population has driven up health care costs. From 1930 to 1973 the percentage of our population over 65 years of age increased from 5.4% to over 10%, a figure which is expected to continue increasing. Because our aging citizens require a greater number of instances and a higher intensity of care than our younger population, that percentage increase represents a real increase in health care costs. Older people generally require increased physician visits, more hospital admissions, greater lengths of stay, and increased rehabilitative periods.

Third Party Payers

Another reason hospital costs are increasing is lack of financial incentives for consumers to avoid hospitalization. In New York State less than 10% of the inpatient hospital payments are made by the patient himself, leaving over 90% to be paid by third party payers. Frequently, patients do not even find out what the total charges were after leaving the hospital, much less being aware of

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* Statement by Mrs. Dorothy P. Rice, Director, National Center for Health Statistics, before the Senate Health Subcommittee on Health and Scientific Research, Committee on Human Resources, March 31, 1977.

them upon admission. This presents serious cost control difficulties for hospitals and for third party payers.

Government Regulation

Increasing government regulation has resulted in increased costs to hospitals. For example, on April 12, 1977, HEW issued a set of "Proposed Quality Control and Proficiency Testing Requirements Applicable to Laboratories of Medicare Hospitals." These regulations would require hospitals participating in the Medicare program to meet specified standards of quality control and proficiency testing which are more stringent than those presently in effect. We do not disagree that increased quality control mechanisms are needed in clinical laboratories because of the complexity of laboratory procedures as well as the large volume of tests performed. However, these quality control procedures are expensive, and the mandated educational requirements will increase the cost of hiring qualified lab personnel. It is not rational to increase the regulation and constraints upon hospitals and simultaneously say that there are no funds available to pay for compliance with these mandates.

Last fall, the Hospital Association of New York State's Task Force on Regulation determined that there are at least 164 agencies involved in the regulation of New York State hospitals (copy enclosed). We encourage increased efforts to reduce duplicative and costly regulations.

POSITIVE ASPECTS OF THE COST CONTAINMENT ACT

This bill would be easy and inexpensive to implement and administer and could be reasonably expected to bring the immediate savings the Administration predicts. It also contains a disclosure provision which would make hospital rates available to the public in order to create a better understanding of hospital rate structures by consumers. Finally, the concepts proposed in Title II, making an effort to place a reasonable limit on capital construction could, within the framework of the planning process and with some modification, be one ingredient for a workable long-term solution to the increase in health care costs.

WEAKNESSES OF THE ACT

Conceptual

The problem of increasing health care costs is broad and multi-faceted. Any measure, temporary in intent or not, to deal with this problem by imposing arbitrary controls on one segment of the health care delivery system must be, and is, inequitable. S.1391 is a simplistic effort by the Administration to place a stop-gap limit on the increase in revenue for merely one segment of one industry -- thus, we take issue with the bill's entire concept. We recommend a coordinated effort to reassess our health care priorities and to move positively toward solutions as described in our Statement for Provision of Health Services to the Citizens of New York State (Appendix I).

Section 124 of S.1391, which authorizes wage pass-throughs for non-supervisory personnel only, is discriminatory and directly contradicts the purpose of this legislation. Further, this would erode the wage differentials between supervisory and non-supervisory personnel. To grant such increases to non-supervisory personnel only would place employees most typically subject to unionization in the same situation which formerly existed in New York -- unions will argue to mediators, arbitrators, and Boards of Inquiry that a wage increase would cost hospitals nothing and, therefore, would be in the best interests of everyone involved. In fact, there would almost be mandatory wage increases for non-supervisory personnel during the 18-month period when a wage pass-through would be automatic. The stated purpose of this bill is to control the increase of hospital costs. Since the cost of labor is such a large component of the hospital dollar, the pass-through of non-supervisory employees' wages (albeit for a short period of time) directly contradicts that stated purpose.

Next, the trending factor for computing the inpatient hospital revenue increase limit is figured from the increase in hospital costs during 1975 and 1976. This trending factor benefits hospitals which had sharp increases in costs during '75-76 and penalizes hospitals with more moderate increases. The latter group would thus be penalized for exercising the greatest constraints during the prior two years.

We feel that the exception criteria prescribed by this legislation is far too restrictive. To receive an exception, a hospital must prove that it is in danger of insolvency, and even the introduction of a new service will not in itself provide for an exception and can therefore be an ex post facto penalty. In addition, this directly contradicts the planning program established by Congress under P.L. 93-641, under which a planning agency certifies that the services being implemented by hospitals are in fact necessary. It is contradictory to approve an added service and then not reimburse the hospital for providing that service. Again, our health care "Statement" addresses the issue of due process.

Our final conceptual criticism of the "Cost Containment Act of 1977" is that it is not a management approach to the containment of costs for the delivery of health care, but an approach where the ends justify the means. Under this legislation, hospital managers would be left with very little direction to go -- for positive incentives are generally lacking in this legislation. The hospital manager is in a void with only a bottom line figure and fiscal sanctions awaiting him as he progresses through his fiscal year. Further, unpredictable volume changes occurring during the last few weeks of an accounting year could cause a hospital to exceed the volume limits and thereby disrupt the cash flow for the first months of the new year. Hospital administrators would experience extreme difficulty in trying to manage their institutions under this legislation.

Technical Deficiencies

The use of the GNP deflator as a price index for measuring the increase in hospital costs is highly inappropriate. HEW has stated in their summary of this legislation that "a formula based on the overall rate of price increases in the economy will reflect increases in the costs of the things hospitals buy, in most instances." We disagree with that statement because the goods and services required in providing hospital care differ in type and relative weight from those composing the general economy. Other deficiencies exist in the GNP deflator which make it a highly inappropriate index to use. Appendix II is a letter from the Commerce Department to our Association making it perfectly clear that the GNP deflator is not an appropriate method for projecting increases in hospital costs. This statement is supplemented by Appendix III, an excerpt from the Quarterly Economic Report which describes the GNP deflator.

Our second technical disagreement is with the bill's definition of a hospital inpatient admission found in section 122(d). This definition includes as admissions, transfers between inpatient units of the same institution. We are concerned that these transfers have no valid reason for being considered admissions, have never been considered admissions in the past, and will require yet another addition to the already oppressive record-keeping requirements for hospitals.

Our final technical point is to question which population figures will be used for the disbursement of the $2.5 billion this legislation calls for as a ceiling for hospital capital expenditures. The 1970 census figures are far outdated, and interim population figures are still questionable.

WHAT EFFECT WILL THIS LEGISLATION HAVE?

One effect this legislation may well have is to drive new ancillary services outside the hospital setting. We recognize that there are provisions to preclude ancillary services presently being conducted within the hospital from being driven outside. However, that does not provide disincentives for new services, such as CAT Scanners, to be placed in private physicians' offices or clinics in the hospital's vicinity. This contradicts the concept of regionalization and national health planning under P.L. 93-641, and as described in our "Statement" for providing health services.

A second effect of this legislation will be to limit the increase in hospital revenue to a level below the 9% figure commonly cited. This difference is mainly due to the bill's "class of payer" provision. If no class of payer can provide reimbursement to hospitals of greater than 9%, and if this legislation allows other payers to reimburse at below the inpatient hospital revenue increase limit, we are most concerned that the overall revenue increase to hospitals will be far from the 9% limit. In New York, for example, the figure will probably be closer to 3-4%.

THE NEW YORK STATE SITUATION AND S.1391's EXEMPTION PROVISION

The Situation

Appendix IV is a brief and simplified review of the revenue control program under the New York State Cost Control Law. This review states that hospitals in New York State have been under a program of cost control since 1969, a period of over eight years. Although our law is called the "Cost Control Law", in reality it is a method of revenue control which covers approximately 50% of the revenues of the hospitals in the state (27% Blue Cross and 23% Medicaid).

The budget problems which have beset New York City and more recently New York State have been directly reflected in the Blue Cross and Medicaid rates paid to hospitals. Chapter 76 of the New York State Laws of 1976 identifies this budgetary problem and includes hospitals in the solution. This is accomplished by decreasing the hospital's revenue from Medicaid (and thus Blue Cross since they are "coupled" under a Department of Health interpretation) based on the fact that the New York State government simply cannot afford to pay for the reasonable cost of providing services. This problem can exist whenever the major purchaser is also the agency which establishes standards and rates of payment for services provided by hospitals.

Under the Cost Control Law, reimbursement to hospitals since 1970 has been gradually becoming tighter and tighter. The 1977 rate

has resulted in a Medicaid (and Blue Cross) reimbursement rate to hospitals which in the aggregate will approximate or be less than the 1976 rate. With costs rapidly increasing, this static rate of reimbursement to hospitals for Medicaid and Blue Cross in New York State is as unacceptable as the 15% increase in reimbursement nationally. In 1975, 153 of 230 (67%) hospitals surveyed by the Association incurred net operating deficits. We are convinced that controlling hospital costs can be accomplished more rationally by the approach specified in our Statement for Provision of Health Services to the Citizens of New York State than by the regulations implementing the Cost Control Law.

S.1391's Effect on New York State Hospitals

Under the New York State system, hospitals are penalized if certain volume levels for specified services and procedures were not attained in the base year. This results in an incentive to increase volume and to meet all the required levels during any given year. However, S.1391 would do just the opposite by establishing a volume corridor of +2% and -6%, resulting in an incentive to decrease volume. Therefore, if this legislation were passed, a hospital in our state would have federal incentives to decrease volume and state incentives to increase volume. For this reason, we highly recommend that state programs be consistent with those of the federal government. In any event, it should be mandated that state programs not be allowed to be inconsistent with federal programs.

Under this legislation, a number of our hospitals would be hit by the 9% ceiling for Medicaid despite that program's overall increase in New York State being near 0%. This is because the State's reimbursement formula produces such a random dispersion of reimbursement levels that many hospitals are either penalized or rewarded unjustly.

Finally, passage of this legislation will make it increasingly more difficult for our hospitals to recruit health care professionals because our reimbursement level will remain lower than that of other states.

New York State Exemption

Section 117(b) of this legislation provides that a state which would have at least 50% of all inpatient care revenues (less Medicare) under its control for twelve months prior to the date of its request may be granted an exemption if by the date of the request it has a program which would then control 100% of the inpatient care revenues (less Medicare). If New York State is granted an exemption under this provision, it could be expected that all payers would fall under the Cost Control Law of 1969 and would then be subject to constraints similar to those presently controlling Medicaid and Blue Cross. Keeping in mind that two-thirds of our hospitals incurred net operating deficits in 1975 with approximately 50% of all reimbursement under state control, it is not difficult to see what would happen if the remainder of the reimbursement mechanisms were

placed under state control. We decry this unreasonable administration of a federal program and request that New York State not be granted an exemption from the Cost Containment Act of 1977.

Recommendations

First, we recommend that you not enact the "Hospital Cost Containment Act of 1977" or any other temporary measure which would implement unfair and inequitable controls over the increase in hospital revenue.

Instead, we offer the following positive recommendations.

For any mechanism implemented to limit the increase in the cost of health care, we encourage you to closely analyze the cost containment efforts of each of the states prior to issuing a waiver. There are various fair and equitable methods of administering a program which is directed toward controlling hospital costs, but certainly a program such as in New York State which has resulted in two-thirds of the hospitals experiencing operating deficits is not one of them.

Senator Talmadge has introduced a slightly modified version of last year's S.3205, the "Medicare/Medicaid Administrative and Reimbursement Reform Act". This bill, S.1470, is an effort to move more positively toward a fair and equitable long-range reimbursement system for hospitals. Although the Talmadge proposal is not a

panacea, we feel that with modification it can solve many of the problems in the health care field. We encourage Congress, along with the health care industry, to take a serious look at this proposal and begin making efforts toward an acceptable long-term solution to the problem of increasing hospital costs.

As mentioned above, our Statement for Provision of Health Services to the Citizens of New York State is enclosed. This statement supports the Health Systems Agencies as a mechanism for coordinating the planning and implementation of changes in the health care system. It also recognizes the advantages of regionalization for the use of health care resources, and places emphasis on due process as a requirement for adding or shrinking the health care system. Finally, the statement addresses itself to reimbursement as a fundamental and inseparable component of health policy in recognizing that institutions established for the delivery of health care are valuable assets in the community and the stability of these institutions must be assured if we are to maintain our high level of health care.

The effort Congress is presently making in H.R.3 and S.143 to eliminate the fraud and abuse in Medicare and Medicaid will result in cost savings for these programs. In addition, these efforts will help rid the system of some of the providers who are not doing the same honest and competent job as most of our hospitals.

We encourage any efforts to reduce the regulatory duplication reported by the Association's Task Force on Regulation. This is a positive step toward reducing the complexity and man hours involved in the provision of health care, and thus must result in a reduction of the costs involved.

In conclusion, we would like to point out that our hospitals are presently undertaking many projects under their own volition to cut increases in hospital costs. First, shared services activities by our hospitals are resulting in over $1 million of annual savings. Over 50% of these programs were initiated after January 1, 1971.

Our Association provides non-profit consulting services to our hospitals in the areas of capital financing, management engineering, personnel and labor relations, financial consulting, continuing health care service, and planning and development. Additionally, these non-profit services include a utilization information service which provides a discharge abstract service, a resource monitoring system used to develop productivity standards, and an education service which annually runs educational programs for over 3,000 hospital managers and other employees.

By the methods cited above and others, New York State hospitals are constantly becoming more efficient in the delivery of health care. However, recognizing that there are many problems yet to be solved, we stand ready to work with government and the public to develop a system to stem the increasing costs of health care.

APPENDIX I

STATEMENT FOR PROVISION OF HEALTH SERVICES

TO THE CITIZENS OF NEW YORK STATE

Hospital Association of New York State, Inc.

3/10/77

PRECIS

American health care priorities must be reassessed in light of the fiscal realities of the 1970's. A dialogue among the Public, Government, and Health Industry is an absolute prerequisite to this reassessment. To stimulate this dialogue, the Hospital Association of New York State has developed this Statement for Provision of Health Services to the Citizens of New York State. The Statement supports the Health Systems Agencies as a mechanism for coordinating the planning and implementation of changes in the health care system and charges the health industry to fully participate in the process. All levels of government are called upon to allow the Health Systems Agencies an opportunity to realize their goals. Regionalization is recognized as a method of rationalizing the use of health care resources. If this mechanism is to be effective and equitable comprehensive planning, including due process protection, must be utilized in developing and actualizing proposals which act to expand or shrink health services. The Statement also addresses itself to reimbursement as a fundamental and inseparable component of health policy. The Statement offers a prototype prospective financial methodology which would provide adequate and predictable revenue levels. The Hospital Association of New York State is committed to a total health policy which, by addressing all of these vital concerns, will strike an appropriate balance between socially developed health care quality standards and reasonable levels of health care costs.

1970's: A TIME TO REEXAMINE HEALTH CARE PRIORITIES

Recent decades have witnessed the growth of health care into one of the nation's largest industries. From 1950 to 1975, proportional American health care expenditures have increased by 78%. 1/ Within these expenditures, much of our country's changing consciousness is mirrored.

The Camelot Climate of the 1960's was nowhere more apparent than in the massive programs of Medicare and Medicaid which brought health care to the poor and elderly. As part of the Johnson Great Society, these programs served to redefine the "rights" of Americans. Beyond their initial fiscal impact, however, lay the realization that public expectations expanded in geometric proportions with each dollar expended.

The Seventies have proved themselves a time of reckoning in many areas of American life. We have come to realize that the best of intentions are often accompanied by seemingly intolerable price tags. The Viet Nam War, Watergate, spiraling inflation, unemployment and resource shortages have forced Americans to exchange their altruistic naivete for a new reality.

It is in the stark light of these realities that all Americans must rethink their approach to health care. They must arrive at an approach that accommodates their pocketbooks, as well as their hearts.

Clearly, the success of any approach is predicated on it being a joint venture of the Public, the Government and the Industry. The Health Care Industry can make an invaluable contribution to this process by combining our expertise with frank recognitions of our own shortcomings. Our failure to take the initiative in confronting the complex issues of our industry dooms us to a reactive role in the determination of future American health policy. We of the Hospital Association of New York, therefore, are putting forth this Statement to be used as a working document in channeling the necessary joint efforts on the national, state, and regional levels towards the needs of the fast approaching Eighties.

The recent past is littered with unsuccessful, piecemeal approaches. Each attempted to solve the complex issues underlying the current health care crisis by focusing solutions on isolated facets of the problems.

1/

NATIONAL HEALTH EXPENDITURES

	1950	1955	1960	1965	1970	1974	1975
Total Expenditures Percent of GNP	4.6	4.6	5.2	5.9	7.1	7.7	8.2*

*Estimated

Source: U.S. Bureau of the Census: Statistical Abstract of the United States, 1975, Washington, D.C., U.S. Government Printing Office, 1975, p. 70.

There is an array of statistics that can be analyzed as indicators of the health care situation (Appendix I). Much of this situation, however, precludes simple statistical comparisons. 2/ The use of individual numbers is useful in assigning blame, not seeking solutions. What has resulted from these actions is an adversary environment where the only due process is provided by the courts (Appendix II).

Legal, fiscal and political constraints have been significant to barriers to change. Working within this adversary environment, meaningful communication to correct our joint concerns has been unproductive. The proposals which follow are designed to be reviewed as an entirety. Taking any one out of context destroys the synergism of the whole.

We also have concern that these proposals may be misused in the present climate of litigation, as has already happened with our recent statements on shrinkage of the system. 3/ We recognize this risk and can only hope that this will not happen again.

HSA'S: A CALL FOR SUPPORT AND PARTICIPATION

The need for a sense of totality goes beyond the use of this proposal. It must become the cornerstone upon which new approaches to health are built. Only a coordinated planning effort can equitably balance America's insatiable health needs and its finite fiscal and human resources.

Though as yet unproven, we believe that the structure of the Health Systems Agencies (HSA) 4/ has the potential for providing this coordination. To realize this potential, it is essential that all the parties work through the structure. New York hospitals, in particular, have been caught in the crossfire of State and Federal policies. The resulting spate of duplicative and conflicting regulations 5/ waste resources which could be put to better use in rationalizing the system. The hospitals, too, must work through the structure if its outcome is to equitably address everyone's needs.

We call on all hospitals to support the HSA's through increased cooperation and informational input.

Though sponsored by the Federal government, other levels are failing to give the HSA's an adequate opportunity to deal with the complex health care issues. In New York, there is already talk of executive branch appointments of a city and a state health "Czar" to oversee all health care issues. The imposition of such a superstructure would allow this sector to circumvent the process which is designed to include the Public, the Health Care Industry and the Government in health policy decisions.

2/ For example the rising cost expenditures of the Seventies must be coupled with the decade's 15% decrease in coronary mortalities for an accurate picture of current health care.

3/ Question 56, Defendants First Set of Interrogatories to Plaintiffs, dated February 4, 1977, HANYS v. Toia, 76 CIV.2027, (SDNY).

4/ Established by the Health Planning and Resources Development Act of 1974 (P.L. 93-641).

5/ According to studies performed by HANYS there are 164 agencies regulating New York hospitals.

We ask all levels of Government to work through the HSA's structure; joining with the Public and the Health Industry in developing health care policy.

REGIONALIZATION: A MECHANISM FOR FUNCTIONAL AND GEOGRAPHIC RATIONALITY

No issue needs greater input and cooperation by all parties than regionalization. As illustrated in the following table which delineates several of the HSA's top priorities, the concept of regionalization is inherent to the mandate of the P.L. 93-641.

TABLE I

HSA PRIORITIES

Primary care services for medically underserved populations, especially rural or economically depressed areas.

Multi-institutional systems for coordinating or consolidating institutional health services.

Developing multi-institutional arrangements for sharing support services.

Development, by health service institutions, of the capacity to provide various levels of care on a geographical basis.

Reimbursement changes that stimulate regional decision making and tie plan decisions to available money supply.

Despite this attention, regionalization remains a much abused and misunderstood concept. Regionalization is a mechanism for rationalization, not necessarily reduction, of the health care dollar. As such, it must be equally concerned with developing needed services as it is with eliminating duplicate ones. Those charged with its implementation must go beyond mere mileage to evaluate access to health care; cognizant of functional and geographic considerations. Only through a comprehensive and professional planning effort will the potential benefits of regionalization be realized. When fiscally expedient measures are presented under the guise of regionalization, they only cloud and jeopardize its true merits.

In discussion of regionalization, there has been much attention, though little action, focused on hospital closures. 6/ The Hospital Association has not shied away from this difficult issue (Appendix III). We recognize that limited resources dictate a shrinkage of the acute hospital system to maintain quality.

We ask the medical staffs, governing boards, and administrative staffs of our membership to prepare self studies to be used in concert with the proposals of the HSA's which identify possibilities for

6/ Shrinkage is used in this Statement in a generic sense to encompass all measures which serve to reduce the acute hospital system; e.g. closure, merger, conversion.

- mergers with other facilities

- conversion to alternate levels of health care

- elimination of duplicate services and facilities and

- services requiring expansion or modernization

The principle of totality must be incorporated into these studies and all those proposing changes in the acute hospital system. Only when viewing the hospital in its entirety can the complexity of making effective and equitable changes be appreciated.

The hospital is the meeting point for service, teaching, and research within health care. It is through this vital partnership that modern medicine has attained the heights which Americans have come to expect. In addition to preserving the viability of each of these endeavors, measures which act to shrink the number of hospital beds must maintain the physician's access to acute settings. Without such access, the physician's ability to practice is severely hampered. Imprudent closures, then, threaten the State's valuable supply of physician resources.

The hospital is also a component of the economic structure of its surrounding community. As a business, the hospital is an employer, a purchaser and often a builder having both long and short-term debts.

Because these different roles can act to fiscally counter-balance and minimize reductions expected from closures,

a Fiscal Impact Statement assessing the net fiscal impact on the State and local budgets should be required as a part of each shrinkage proposal. The Statement should include, but not be limited to:

- reduction in Medicaid expenses

- increases in unemployment benefits, home relief expenditures and aid for dependent children

- availability of alternate sources of employment

- the effect upon property payroll and sales tax revenue

- the effect on state and local credit

- attractiveness for industrial location

In the best of circumstances implementation of major change is fraught with difficulties. To minimize the trauma, two principles must become part of standard procedure when closure, merger or conversion of services is considered. As discussed, the hospital is a complex organization with a

variety of roles and responsibilities. Any shrinkage proposal must be the product of an integrated planning effort; addressing itself to all of the ramifications entailed by the change. The earlier this is done, the faster unfounded fears can be put to rest. The premature publication of hospitals and services being considered for elimination raises more questions than it answers. 7/

All proposals for shrinkage of the acute hospital system must directly address the applicable issues of:

- alternate sources of health care for the community
- physical plant abandonment
- employee job placement
- real availability of physician staff privileges at other hospitals
- maintenance of training programs, e.g. Schools of Nursing
- disposition of medical records
- maintenance of malpractice coverage for claims filed after closure
- equitable disposition of the assets and liabilities 8/
- fiduciary responsibilities of Governing Board

A second principle, all parties must be afforded due process as actions of development and implementation of system changes affect them, must also become part of the standard planning procedure. As discussed more fully in Appendix IV, the protection of due process is a legal right. It is a right, however, which has repeatedly been abridged by the State in its dealings with the hospital community. This lack of due process is the most significant factor in creating the adversary environment which has come to characterize New York State. Due process must again be inherent to the procedures which develop all important regulations. In the shrinkage issue, due process is fundamental to assure effective and equitable planning.

REIMBURSEMENT: AN INHERENT COMPONENT OF HEALTH POLICY

A reimbursement policy is an equally important component in the formulation of total health policy. There has, however, been too much concern with promulgation of reimbursement rates and too little attention to an overall reimbursement policy which supports desired programs.

7/ "Shut Down of Thirty Hospitals Urged for New York City," N.Y. Times May 28, 1976, p. D-12.

8/ This disposition includes accounts payable and receivable, settlement of long and short term debts, bond issues and restricted requests.

The recent fiscal problems of the State and local governments in New York have vividly illustrated the weaknesses of the current system wherein the major purchaser establishes the standards and price for the desired services. Rather than reasonable costs, governmental budgetary deficits have dictated reimbursement parameters. State regulation of all the third party payors has meant that state cutbacks have had a disproportionate fiscal impact.9/

The time frame used in rate computation is another major flaw in the present reimbursement methodology. Though motives of cost control are laudable, rates which disallow expenses which were incurred two years prior can only be considered punitive. The control of revenue is not synonymous with the control of costs. Cost containment which is effective in both a long and short-term perspective requires the regulation of revenue through

> promulgation of a prospective rate by an independent state agency responsible for coordinating the financing, planning and establishment of quality and utilization standards for the health care industry. To reinforce management initiatives, recognizing the legitimate differences among hospitals and the need for preservation of capital assets, a reimbursement methodology must be built on a combination of cyclical budget review and formula computation.

The principles of such a system are outlined in Appendix V.

COMMUNICATION: A PREREQUISITE FOR MEANINGFUL CHANGE

Implementation of these proposals can be realized through a variety of structures. It is essential that the structure be a flexible, balancing control with an ability to respond and anticipate change in the extremely dynamic environment of health care. One such structure is the Hospital Association's proposal for a State Health Services Commission (Appendix VI). Action prior to the establishment of a formalized mechanism is needed if it is to bring meaningful change to the system.

Channels for communication must be opened among the State, the Public and the Health Care Industry. The direction for New York health care must be decided through joint dialogue.

Through a meaningful and effective dialogue the Government, the Public and the Health Care Industry must move towards seeking:

- a frank recognition of the mutual responsibility for the current problems 10/ and future solutions.

9/ Because of the intertwining of the Medicare, Medicaid and Blue Cross rates, to reduce $25 million in State expenditures, some $350 million is to be cut from the hospital system through the 1977 Part 86 amendments.

10/ For example, it should be noted that the State has given prior authorization for all health care facilities and services built and expanded in N.Y. for the last 11 years.

- public understanding of the complexities of providing quality health care service

- an appreciation that financing and program are inseparable in the health industry

- a readjustment of public expectations for health services which are in line with available resources

This statement is a commitment by the Hospital Association of New York to that dialogue and to the people of New York.

95-195 O - 77 - pt. 2 - 25

APPENDICES

Hospital Cost Comparisons ..... I.

Recent Health Industry Litigation Against New York State ..... II.

Hospital Association Letter January 10, 1977 ..... III.

The Meaning of "Due Process" ..... IV.

Principles for Prospective Reimbursement ..... V.

Principles of the HANYS Proposal for a State Health Services Commission ..... VI.

APPENDIX I

HOSPITAL COST COMPARISONS

New York State costs for hospital care are, on a per capita basis, substantially higher than the U.S. average. Specific hospital cost factors, such as per diem costs and case costs, are also substantially higher than national averages.

A meaningful evaluation of hospital costs in New York State cannot, however, be achieved by comparing NYS and US averages.

The rural/urban mix of NYS (excluding New York City) closely resembles that of the US as a whole: 74% urban for the US, 75% urban for NYS (excl. NYC). NYC should be compared with other large cities.

Upstate NY has an average length of stay of 8.8 days for community hospitals compared to the national average of 7.7. The average length of stay of NYC hospitals is 11 days compared to 8.4 days weighted average for the 100 largest US cities.

Per diem costs of NYS hospitals (excl. NYC) are 98% of the US average. Case costs for NYS (excl. NYC) are 112% of the US average reflecting the longer length of stay in NYS (excl. NYC.).

The per diem costs of NYC hospitals are 123% of the weighted average of the 100 largest US cities. Case costs for NYC are 161% of the 100 largest US cities average reflecting longer length of stay in NYC.

The above comparisons include the effect of a higher cost per employee for NYS hospitals as compared to national data. NYS (excl. NYC) hospitals have a cost per employee that is 107% of the national average. NYC hospitals have a cost per employee that is 127% of the 100 largest US cities average.

After adjusting for different wage levels, a comparison of per diem and case costs yields substantially different results.

NYS (excl. NYC) per diem costs become 94% of the national average, while case costs become 108% of the national average.

NYC per diem costs become 108% of the 100 largest US cities average, with the case costs becoming 141% of the 100 largest US cities average.

NOTES: (1) All of the hospital data in this report is for community hospitals. Community hospitals are defined as all non-federal short-term general and other special hospitals -- excluding hospital units of institutions -- whose facilities and services are available to the public.

(2) All data is for 1975 except that relating to the NYC/100 largest US cities comparisons. The latter is for 1974.

(3) Patient day cost and case cost comparisons are based on adjusted data applying statistics adjusted for outpatient volume to total hospital expenditures as per the AHA Guide Issue Methodology.

It should be recognized, however, that while the length of stay and unadjusted case costs of NY hospitals are higher, when national comparisons are made, another key determinant of cost, the admission rate, is below comparable national figures. NYS (excl. NYC) has an admission rate which is only 89% of the national average. NYC hospitals have an admission rate which is only 66% of the weighted average of the 100 largest US cities.

Per capita costs for community hospital care, the bottom of the line cost figure, shows that NYS (excl. NYC) is at 101% of the national average, while NYC is at 108% of the average of the 100 largest US cities, with 34 cities having higher per capita costs.

The bottom line figures change significantly when wage adjusted data is used. NYS (excluding NYC) hospitals are at 97% of the national average after adjusting for differences in wage levels. NYC hospitals are at 94% of the average of the 100 largest US cities after making the wage adjustments.

COMPARISONS WITH OTHER ECONOMIC SECTORS

Some of the exogenous political, social and economic factors impacting on the hospital industry also impact on other sectors of the economy. The relationships are far from direct, and documenting the parallels and the differences is a task considerably beyond the scope of this paper.

Much of the relevant data is in a form which precludes easy comparison of any except statewide statistics. An example is the effect of rural/urban mix, the impact of which can obviously vary as to economic sector. It may, nevertheless, serve a useful purpose to consider together data comparing both the NY hospital sector and other sectors of the NY economy, particularly those relating to human services, with the national averages. Table II provides such a comparison for various public sector activities.

Table III provides a breakdown of the Public Welfare, Health and Hospitals sector.

It should be noted that public sector Public Welfare, Health and Hospitals expenditures per capita reflect not only NYS/US cost differentials but also reflect that a larger part of the total health care costs are met by government as opposed to the private sector.

The comparisons shown in Tables II and III indicate a general pattern of greater expenditures for human services, as well as other activities, by New York state and local government. New York state has a per capita income of 112% of the national average, however, state and local taxes are 154% of the national average.

It is noteworthy that in the NYS/US comparison the Health and Hospitals sector is relatively higher for NYS than any other sector except 'Interest on General Debt.'

COMPARISON OF WAGE RATES

Wage rates, in general, are higher for NYS than the US. Table III provides statistics for selected industries. Geographical distribution of industries within NYS and nationally can effect results, thus leading to possible distortions in inter-industry comparisons. The conclusion that hospitals are not alone in paying wages above the national average is, however, supported by the data.

COMPARISON OF NON WAGE STATISTICS

Table V provides a comparison for a limited number of non-salary costs. The items studied indicate a higher relative cost in New York State.

Fuel costs of New York State hospitals are also higher due to a variety of factors including the greater use of lower cost natural gas by other US hospitals, the lower sulfur requirements pertaining to fuel oil, particularly in New York City, transportation costs and climatic differences.

These non-wage results are indicative only, in view of the limited scope of items compared.

TABLE I

COMMUNITY HOSPITALS COMPARISON

	Average Length of Stay	Admissions per 1000 population	Per Diem Cost	Case Cost	Per Diem Cost (wage adjusted)	Case Cost (wage adjusted)	Cost per Capita	Cost per Capita (wage adj.)
New York City (5 Boroughs)	11.0[a]	156.37[a,c]	168.26[c]	1850.86[a,c]	147.11[*a,c]	1618.21[a,c]	333.10[c]	291.23[*a,c]
100 Largest U.S. Cities	8.4[a]	237.00[a,c]	136.81[c]	1149.20[a,c]	136.81[*a,c]	1149.20[a,c]	309.08[c]	309.08[*a,c]
NYC as percentage of 100 Largest U.S. Cities	131%	66%	123%	161%	108%	141%	108%	94%
(1974)								
New York State (excluding New York City)	8.8[b]	139.34[b,d]	131.11[b]	1153.77[b]	126.16[**b]	1110.21[b]	184.13[b,d]	177.17[**b,d]
United States	7.7[b]	156.88[b,d]	133.81[b]	1030.34[b]	133.81[**b]	1030.34[b]	182.81[b,d]	182.81[**b,d]
New York State (excluding New York City) as percentage of United States	114%	89%	98%	112%	94%	108%	101%	97%
(1975)								

* 100 Largest Cities weighted average used as base.
** United States weighted average used as base.

Note: Patient day cost and case cost comparisons are based on adjusted data applying statistics adjusted for outpatient volume to total hospital expenditures as per the AHA Guide Issue Methodology.

SOURCES:

a. Hospital Statistics, 1975 Edition (1974 Data from the AHA Annual Survey), American Hospital Association, Chicago, Illinois

b. Hospital Statistics, 1976 Edition (Data from the AHA 1975 Annual Survey) AHA, Chicago, Ill.

c. Health Expenditures in New York City: A Decade of Change, Nora Piore, Purlaine Lieberman, James Linnane, Center for Community Health Systems, Columbia University Faculty of Medicine, N.Y., N.Y., 1976

d. Bureau of the Census, U. S. Department of Commerce (1975 data)

DESCRIPTION AND CALCULATION REFERENCES

BASIS INDICATOR	DESCRIPTION	CALCULATION
Average Length of Stay	Average number of days inpatients spend in the hospital	Inpatient Days ÷ Discharges (The admissions instead of discharges were used for the 100 largest cities)
Admission per 1,000 population	Number of inpatient admissions (excluding new borns) per 1,000 resident population	Admissions ÷ Resident population
Per Diem Cost	The total hospital expenses in terms of adjusted patient days. The adjusted patient days represent the number of days of inpatient care plus an estimate of the volume of outpatient services, expressed in units equivalent to an inpatient day in expense.	Total Hospital Cost ÷ Inpatient Day Equivalents
Case Cost	Average cost of a hospital case	Per Diem Cost x Average Length of Stay
Per Diem Cost (Wage Adjusted)	Per Diem Cost adjusted by differentials in salary levels.	Total Wage Adjusted Hospital Expenses ÷ Adjusted Patient Days
Cost Per Capita	Hospital cost per resident population	Total Hospital Cost ÷ Resident population
Cost per Capita (Wage adjusted)	Wage adjusted hospital cost per resident population	Total wage adjusted hospital expenses ÷ resident population

Methodology of calculating wage adjusted hospital expenses:

		e.g. NYS (excluding NYC) (in $1,000)
1) Total hospital expenses (1975)	=	1,942,895
2) Payroll Expenses	=	- 1,067,710
3) Non-payroll expenses (1) - (2)	=	875,185
4) Wage adjustment factor (Average U.S. Salary per FTE* ÷ Average N.Y. Salary per FTE)	=	0.93127
5) Wage adjusted payroll expenses (2) x (4)	=	994,326
6) Total wage adjusted hospital expenses (3) + (5)	=	1,869,511

* 100% largest cities weighted average was used in adjusting N.Y.C. hospital expenses

TABLE II

DIRECT GENERAL PER CAPITA EXPENDITURES OF STATE AND LOCAL GOVERNMENT

SELECTED SECTORS

1974 - 1975

	New York State	United States	New York as percentage of U.S.
Education	$495	$412	120%
Highways	85	106	80
Public Welfare and Health and Hospitals	423	216	196
Police Protection	59	39	151
Fire Protection	21	16	131
Sewerage	41	25	164
Sanitation (Other than Sewerage)	20	10	200
Local Parks and Recreation	21	16	131
Financial Administration	18	17	106
General Control	32	24	133
Interest on General Debt	106	41	259
All Other General Expenditures	290	155	187

SOURCE: Governmental Finances in 1974-75, U.S. Department of Commerce, Bureau of the Census, Sept., 1976 (GF75 No. 5)

NOTE:

Direct General Expenditure of State and Local Government - All expenditures other than intergovernmental expenditures, utility expenditure, liquor store expenditures, and insurance trust expenditures.

TABLE III

COMPARATIVE PER CAPITA EXPENDITURES* OF STATE AND LOCAL GOVERNMENT, 1974-75

	New York State		United States		
	Per Capita Expenditures	% of Public Welfare & Health & Hospital Expenditures	Per Capita Expenditures	% of Public Welfare & Health & Hospital Expenditures	New York State as Percentage of U. S.
Public Welfare & Health & Hospitals	$ 423[a]	100%	$ 216[a]	100%	196%
Public Welfare excluding medical care	154[a]	36	83[a]**	38	186
Health & Hospitals	269[a]	64	133[a]**	62	202
Hospital	92[b,c]	22	N.A.	N.A.	N.A.
Mental Hygiene	52[d]	12	N.A.	N.A.	N.A.
Long Term Care	57[e,f]	14	N.A.	N.A.	N.A.
All Others	68	16	N.A.	N.A.	N.A.

* Includes all general expenditures disbursed by state and local government and excludes all direct federal government expenditures to recipients,e.g., Medicaid expenditures are included, Medicare expenditures are excluded.

** The breakdown of public welfare and Health and Hospital expenditures was derived from Governmental Finance in 1974-75, published by the U.S. Department of Commerce. There are discrepancies between this information and those derived from Social Security Administration; the U.S.D.O.C. data for N.Y.S. sources.

Sources

a. Governmental Finances in 1974-75, U.S. Department of Commerce, Bureau of the Census
b. New York State Department of Health, Health Economics Division (unpublished data).
c. Uniform Financial Report for Hospitals, 1975
d. New York State Department of Mental Hygiene (unpublished data)
e. Annual Report of the Comptroller, State of New York 1975
f. New York State Department of Social Services

TABLE IV

COMPARATIVE WAGE STATISTICS

(1975)

Employment	N.Y. State	United States	New York State as a Percentage of United States
Manufacturing*	$ 191[a]	$ 190[b]	101%
Transportation & Utility*	250[a]	234[b]	107
State & Local Government Employees (Oct.1975)**	1136[c]	955[c]	119
Contract Construction*	317[a]	265[b]	120
Wholesale & Retail Trade*	158[a]	127[b]	124
COMMUNITY HOSPITAL (FTE)***	10977[d]	8635[d]	127
Banking*	169[a]	129[b]	131
Hotels*	137[a]	90[b]	152

* Average Weekly Earnings of Production or Non-supervisory Personnel
** Average Monthly Wage
*** Average Annual Wage

SOURCES

a. Employment Review, New York State Department of Labor, May 1976, Vol.29, No.5

b. Employment and Earnings, U.S. Department of Labor, Bureau of Labor Statistics, March 1976, Vol. 22, No. 9

c. Public Employment in 1975, U.S. Department of Commerce, Bureau of the Census (information obtained by phone from the U.S. Bureau of the Census, Dec.1976)

d. Hospital Statistics, 1976 Edition (Data from the AHA 1975 Annual Survey), American Hospital Association, Chicago, Illinois

TABLE V

COMPARATIVE NON WAGE STATISTICS
(1975)

Food Cost[a]	
New York/Northeastern New Jersey as percentage of U.S. Metropolitan Areas	112%
Buffalo as percentage of U.S. Metropolitan Areas	101%
Electricity Cost[b]	
New York State as percentage of U.S. Average	163%
Gas Cost[c]	
New York State as percentage of U.S. Average	147%
Telephone Cost[d]	
New York City as percentage of Los Angeles	164%
New York City as percentage of Philadelphia	155%

Sources

a. BLS Revised Estimates for Urban Budgets & Comparative Indexes for Selected Urban Areas, Autumn 1975, U.S. Department of Labor, Bureau of Labor Statistics

b. Edison Electrical Institute, Statistical Yearbook for 1975

c. Gas Facts for 1975, American Gas Association

d. Exchange Service Telephone Rates in Effect June 30, 1975, National Association of Regulatory Utility Commissioners

Definitions and Methodology

Food Cost represent food budget for food at home for a family of four. The intermediate family budgets were used. The food budget was constructed based on the total cost of purchasing a market basket of food as determined by the U.S. Department of Agriculture. This market basket allows for regional preference and availability of food at a given level of nutrition.

Electricity Cost was measured by the revenue per KWH for commercial and industrial small light and power usage.

Gas Cost was measured by the revenue per trillion BTU's for commercial usage.

Telephone Cost was measured by the base rate per message unit for a business customer exclusive of sales and excise taxes. It was derived from dividing the monthly base rate for business individual rate service by the total message units allowed.

A. U.S. average of telephone costs was not obtained because the numerous different rate structures make such a comparison extremely difficult.

APPENDIX II

RECENT HEALTH INDUSTRY LITIGATION

AGAINST NEW YORK STATE *

CASE	SUBJECT
Catholic Medical Center v. Rockefeller	(1969 Medicaid)
Adelphi Hospital v. Ingraham	(1973 Medicaid)
Benedictine Hospital v. Ingraham	(1973 Blue Cross)
The Mt. Sinai Hospital v. Ingraham	(1974 Blue Cross)
Beekman-Downtown Hospital v. Whalen	(1974 Blue Cross Settlement)
Long Island College Hospital v. Whalen	(Litigation Expense)
Hospital Association of N.Y. State v. Toia	(1976 Medicaid)
Jewish Memorial Hospital v. Whalen	(1976 Blue Cross)
People v. The Womens' Christian Association	(Blue Cross Contract)
The Medical Society of The State of New York v. Toia	(Part 85 Restrictions)
Kaye v. Whalen	(1976 Nursing Home Medicaid)
N.Y. Association of Homes for Aging, Inc. v. Toia	(1976 Nursing Home Medicaid)
Nassau-Suffolk Hospital Council v. Whalen	(JCAH Confidentiality)
New York University v. Whalen	(1977 Medicaid-Sunshine Law)

*There are also reported to have been in excess of 100 individual institution actions relating to reimbursement against the State during this period.

APPENDIX III

Hospital Association of New York State
INCORPORATED 15 COMPUTER DRIVE WEST ALBANY, NEW YORK 12205 • (518) 458-7940

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SOPHIE P. ZIEGLER, R.N.
Newark
1979
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GEORGE B. ALLEN
Albany

January 10, 1977

Dear Colleague:

The finite fiscal resources of the State have resulted in chronic underfunding of our existing hospital system. After careful study of the options available, the Hospital Association is convinced that in order to maintain quality in light of the current fiscal realities, a shrinkage of our hospital system is necessary. Through such a shrinkage our limited funds can more effectively be utilized to produce the best patient care possible.

There are a variety of measures, including closures, mergers, regionalization and expansion of alternate services, which can realize a reduction in the number of acute care beds. Hospitals, through their administrators, trustees and medical staff must participate fully in this process. To assure that these vital decisions concerning system changes are equitable and effective, professional planning must be utilized and due process must be afforded to both institutions and the public.

To achieve a rational system and preserve the excellent quality of New York health care, the Association makes the following recommendations:

1. The Department of Health in coordination with the HSA's immediately develop a proposal for an appropriate delivery system of health care services throughout the State.

2. Each health care facility in the State give the highest priority to participation and cooperation with the above mentioned proposal and immediately investigate the appropriateness and possibilities for:

   a) complete or partial closure of their facility,

   b) mergers with other facilities,

   c) conversion to alternate services of health facilities,

   d) elimination of duplicate services.

3. All previously approved acute care bed construction be re-evaluated unless construction has commenced.

4. The HSA's and government take an active role in recognizing and acting upon the need for additional beds and services in areas where needs exist, and continue to encourage correction of obsolescence.

5. All costs attendant to the above proposals must be paid for over and above the normal reimbursement formulae.

The Association recognizes that these changes will be exceedingly difficult. Survival, however, of a quality hospital system demands commitment to the totality by all of its parts.

I urge that each of you actively participate in this process.

Sincerely,

Irvin G. Wilmot
Chairman

cc: Personal Members

1A

APPENDIX IV

THE MEANING OF "DUE PROCESS"

"Due process" guarantees a party meaningful notice and opportunity to be heard before being subject to the loss of a substantive right. The Supreme Court has described it as follows: "Fairness of procedure is due process in the primary sense" and "the primary and indispensable foundation of individual freedom." The protection of "due process" is afforded to property as well as to personal rights and extends to business entities as well as individuals.

One of the most cited and compelling explanations of the need for "due process" is that given by Mr. Justice Frankfurter:

> "Man being what he is cannot safely be trusted with complete immunity from outward responsibility in depriving others of their rights. At least such is the conviction underlying our Bill of Rights. That a conclusion satisfies one's private conscience does not attest its reliability. The validity and moral authority of a conclusion largely depend on the mode by which it was reached. Secrecy is not congenial to truth-seeking and self-righteousness gives too slender an assurance of rightness. No better instrument has been devised for arriving at truth than to give a person in jeopardy of serious loss notice of the case against him and opportunity to meet it. Nor has a better way been found for generating the feeling, so important to a popular government, that justice has been done."

This reasoning is particularly applicable to the administration of Part 86. Frequently, decisions affecting health care providers appear to be made without affording these institutions adequate opportunity to express their views or present facts relevant to the determinations under consideration. The result has often been that action is taken by the Health Department and other state agencies on the basis of facts which are subsequently found to be incorrect. A prime example of this is the original imposition of "unacceptable level of care" penalities on hospitals without affording these institutions any due process safeguards. In the case of a least one hospital, facts were brought to the attention of the State, after its determination that an "unacceptable level of care" was being provided, which demonstrated that this finding was based on incorrect information. Had the hospital been given an opportunity to present its position prior to the original determination, such determination need never have been made.

The importance of due process safeguards in the context of certain of the penalties imposed under Part 86 was recognized by the United States Department of Health, Education and Welfare which required the State of New York to amend its Medicaid plan to include "due process" guarantees with respect to "unacceptable level of care" determinations. No similar provisions, however, have been incorporated into the "unacceptable level of care" provisions of Part 86 as they apply to Blue Cross.

Neither have any "due process" protections been provided with respect to the imposition of the other penalites under Part 86 -- either for Medicaid or Blue Cross. Specifically, these include section 86-1.8(f) which provides for penalties within the Health Commissioner's discretion, up to certain limits, for the negligent or willful incorrect completion or failure to file reports, and section 86-1.31 which provides for similar penalties for the deletion of a previously offered service. In all penalty situations, the validity of the State's decision depends almost entirely on its ability to correctly ascertain the facts. As the experience with the "unacceptable level of care" provision

demonstrates, this is more likely to be accomplished with provider input.

Justice Frankfurter's emphasis on the importance of "due process" as a means of establishing "that justice has been done" is also particularly apt in the context of hospital regulation. The State has continually refused to provide hospitals with meaningful input into the promulgation and application of regulations, and has penalized hospitals that seek to vindicate their rights through litigation by such means as refusing to process their rate appeals. Such an atmosphere discourages the kind of meaningful dialogue which is necessary to the resolution of the health care problems in this State.

THE APPLICATION OF "DUE PROCESS" TO PART 86-1

"Due process" is a flexible concept and what it requires will vary depending on the particular substantive right affected. The general law with respect to the constitutional safeguards available in rate-setting is unclear. With respect to Part 86, the New York courts have not found a formal hearing to be a constitutional prerequisite either to rate calculations or amendments to the rate-setting methodology. However, they also have not determined that hospitals can constitutionally be deprived of all input in rate-setting decisions. The new State Administrative Procedure Act (APA) probably makes unnecessary a resolution of what is constitutionally required in Part 86 rate-making since, under the APA, hospitals must be given notice and an opportunity to submit written comments prior to the promulgation of reimbursement rates (including appeal revisions) and amendments to Part 86-1.

The New York Court of Appeals has stated that in quasi-judicial adjudicatory action, "due process" requires "that the parties whose rights are being determined must be fully apprised of the claims of the opposing party and of the evidence to be considered, and must be given the opportunity to cross-examine witnesses, to inspect documents and to offer evidence in explanation or rebuttal..." Actions such as the imposition of penalties under Part 86-1 and the recoupment of alleged overpayments to hospitals are in the nature of what has been traditionally held to be quasi-judicial action and as such should be subject to the due process safeguards described above. In fact, the New York courts have specifically found these safeguards to be necessary when the state attempts to recoup monies from providers for alleged Medicaid overpayments. However, there is very little law with respect to the imposition of civil monetary penalties and none with respect to the penalties provided for in sections 86-1.8(f) and 86-1.31. Consequently, one cannot be certain how these penalties will be regarded by the courts.

The fact that the State is a purchaser of health care services raises a special question in connection with guaranteeing a constitutionally acceptable opportunity to be heard -- namely, the question of bias. It is in the State's pecuniary interest to approve reimbursement rates at the lowest possible level so it can reduce its expenditures. However, the Supreme Court has specifically stated that cases "in which the abjudicator has a pecuniary interest in the outcome" create a "probability of actual bias on the part of the judge or decisionmaker (which) is too high to be constitutionally tolerable." The fact that the Public Health Law does not provide for such independent decision making does not eliminate this constitutional issue.

Thus far we have spoken of "due process" notice as a supplement to the right to an opportunity to be heard on proposed agency action. A party subject to administrative regulation has a right to another kind of "due process" notice -- namely, the right to be clearly and objectively apprised of the standards by which its conduct will be judged. The penalty provisions in

Part 86-1 are overly broad and vague, and do not satisfy this latter "due process" notice requirement. There is no definition of "unacceptable level of care," "incorrect completion" of a report or any other prohibited act in these regulations. These matters are left solely to the subjective discretion of the Hospital Review and Planning Council and the Health Commissioner. The New York Court of Appeals just recently struck down regulations of the Health Commissioner relating to nursing home construction standards because they were also subject to the defect of being purely subjective.

There may be some circumstances which would justify dispensing with due process before depriving a party of property, but such circumstances must be "extraordinary" and "truly unusual," according to the Supreme Court. The mere desire of public officials to effectuate their programs and policies cannot override constitutional protection provided by law. As the New York Court of Appeals has said:

> "Laws are made by the law-making power and not by administrative officers acting solely on their own ideas of sound public policy, however excellent such ideas may be."

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APPENDIX V

PRINCIPLES FOR PROSPECTIVE REIMBURSEMENT

1. The prospective reimbursement methodology should be based upon a staggered three-year cycle of promulgation as follows:

   a. Proposed base year budgets by providers would be reviewed against cost and productivity screens established by the regulatory agency in order to validate allowable costs. Costs in excess of screens would require justification by the provider and the lack of proper justification disallowed partially or fully for prospective rate promulgation. Emphasis in justification above screens should be related to the provider's patient care programs in relation to the specific role of the provider in the regionalization scheme of health planning.

   b. The second and third year of the cycle should be subject to representative inflationary adjustments together with volume, patient mix, and specifically approved cost adjustments based upon appeals, applied to the approved base year costs. The prospective reimbursement mechanism should have the capacity for retroactive adjustment of the inflationary index used to predict cost increases.

   The interim non-review years of the prospective reimbursement cycle should be established by applying an inflation index adjustment to the prior base year costs established by the budget review process. Such adjustments must include an improved inflationary index indicative of the actual "shopping basket" of the provider. Additional factors for changes in intensity for patient mix and changes in volume of care based upon fixed - variable cost concepts should supplement the pure inflation index. The construction of an appropriate index methodology, the design of an intensity factor based upon patient mix and the formula for an automatic volume adjustment should be undertaken by the regulatory agency with participation of the provider industry.

   c. The fourth year would require a re-evaluation of base year costs via the budget review process.

2. The three year cycle stagger system would be initiated in the first year by the regulatory agency for budget review purposes based upon type of hospital, geographic region, size, grouping, classification, or any combination of these factors.

3. The participation of the Federal Medicare program in the State regulatory reimbursement plan is essential and should be requested as soon as possible. Pending such federal participation, total revenue requirements as determined by the cycle process should be reduced by Medicare revenues and the residual requirements applied to all other payors of care under State regulatory authority.

4. A budget review procedure must be based upon a Uniform Accounting and Reporting system. The current New York State mandated regulations and manual may prove to be satisfactory for this purpose. In addition, all cost screen data, grouping methods, inflationary index constructions, and statistical analysis, should be built upon this reporting system.

Should a federally mandated uniform accounting and reporting system be required for Medicare in the future, the currently mandated State system must be modified to conform to Federal standards in order to avoid duplicative internal provider accounting systems.

5. There are several methods on which prospective reimbursement can be based for payment purposes. The average per diem and average per visit units have been misunderstood, have done little to define or express cost of care to the consumer and is overly sensitive to normal fluctuations in volume. The per unit basis for prospective payment should be discontinued as soon as possible. Any proposed replacement must be applied uniformly for these payors.

   Alternative payment methods such as global budget reimbursement, per diagnosis payment, per care payment, etc., may eventually produce a more rational approach to payment. Testing and experimentation on these alternative methods should begin immediately, but should be undertaken only in tandem with current payment methods so that their effect on a provider's ability to render efficient services can be measured.

6. The budget review process must utilize a set of cost screens that are administratively feasible, based upon parameters established within peer group comparison applied to natural provider functional costs centers and related to the provider's designated role in the planning process. The cost screens should be used as "stop and look" indicators by the regulatory agency and not as arbitrary ceilings and limitations. The burden of documenting as reasonable the costs over the screens rests with the provider. The functional cost centers to be used for screening purposes are to be established by the regulatory agency. Productivity screens should be an integral part of the cost screen process to assure a reasonable level of efficiency.

7. The grouping of providers into peer classification is essential for development of cost screens as well as utilization in the index methodology. Improved grouping techniques that are representative of truly similar providers based upon medical program, as well as factors such as size, location, etc., currently used, must be implemented as soon as possible by the regulatory agency in conjunction with the provider industry.

8. An appropriate appeal procedure must be designed that provides effective due process as well as timely resolution. Unsettled matters at the conclusion of such an administrative appeal procedure involving less than some specific percent impact on the provider's operating cost budget should be submitted to an AAA panel of 3 arbitrators for binding decision on all parties. Larger cost factors should follow appropriate judicial relief provision.

9. Rate adjustments for approved capital expansion, mergers and consolidation of providers, medical program improvement, and major unforeseen circumstances not considered by the budget review process or by the inflationary methodologies are proper matters for a special appeal process.

10. The regulatory agency should sponsor certain experiments with selected providers so that the technical aspects of prospective reimbursement can be improved and thus assure that the methodologies are reasonably reflective of the efficient delivery of care by providers.

11. The prospective reimbursement methodologies must recognize losses of the voluntary hospital providers associated with ambulatory care programs to the medical indigent which otherwise would become a public responsibility. The strengthening of the Ambulatory Care Financing Law concept by application to these payors of inpatient care is essential. Appropriate providers must meet regulatory agency and planning authority criteria that establish community service as an integral element of their medical programs. When such a payment method is in effect, the so-called "Ghetto Medicine" subsidy program should be discontinued.

APPENDIX VI

PRINCIPLES OF THE HANYS
PROPOSAL FOR A STATE
HEALTH SERVICES
COMMISSION

* The goal of the State Health Services Commission is to assure that quality health care and related services can be efficiently provided, soundly financed and utilized at reasonable expense.

* The commission must be genuinely independent and free of any conflicts of interest.

* Its powers should be vested in a body of qualified decision makers rather than one person.

* Its authority must include exclusive jurisdiction over all matters within its purview.

* The regulatory functioning of the commission must include due process, appeals procedures, and rights of judicial review.

* Services approved and mandated by the commission must be financed to assure the accessibility of quality health care to all persons.

* The commission would coordinate its functions with other governmental and non-governmental agencies whose functions affect the provision of health services.

U.S. DEPARTMENT OF COMMERCE
Social and Economic Statistics Administration
BUREAU OF ECONOMIC ANALYSIS
Washington, D.C. 20233

July 19, 1974

APPENDIX II

Dr. John Rossman
Director, Health Economics
Hospital Association of New York State
15 Computer Drive West
Albany, New York 12205

Dear Dr. Rossman:

Regarding the application of the implicit price deflator for GNP to project hospital costs, the answer is that this measure would not be appropriate for this purpose.

The implicit price deflator for GNP is the ratio of current dollar GNP to constant dollar GNP. It is not a real index in the sense that it is based on shifting weights that reflect changes in the composition of GNP. Although it is the best single measure of broad price movements in the economy as a whole, it certainly would not be the correct measure to use in any escalation procedure.

If one is concerned with finding a device for offsetting the effects of price increases, one should select price components corresponding to his major materials and labor. To take a simple case, suppose a contract is executed at present costs. Both parties have accepted escalation. Let us assume the vendor's labor cost is 45 percent of the quoted price and materials cost 40 percent (15 percent in this example would represent profit and overhead not subject to escalation). Suppose that between two adjustment dates the selected industry's average hourly earnings have moved up 10 percent and materials prices 7 percent. Then the percent of total price adjustment for labor cost will be 45 percent of 10 percent, or 4.5 percent. The materials cost adjustment will be 40 percent of 7 percent, or 2.8 percent. The total price adjustment will be the sum of the two, or 7.3 percent.

The above is the simplest type of escalation adjustment. The point is that you should determine your cost elements, and pick the right price indexes and earnings data. There is no one magic figure of universal utility.

Sincerely yours,

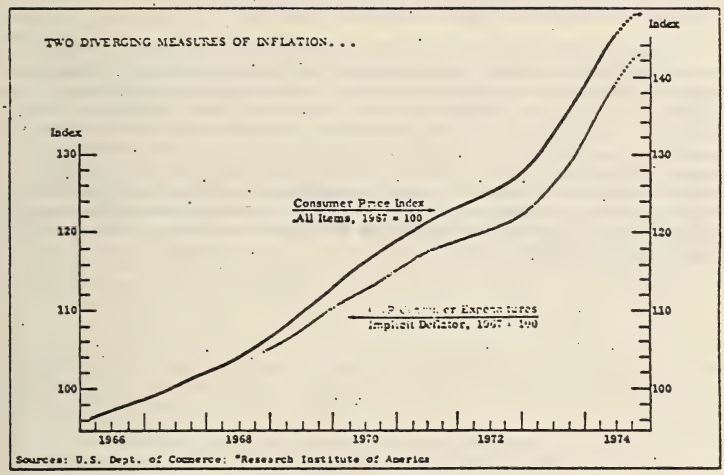
Ago Ambre

AGO AMBRE
Economist

APPENDIX III

EXCERPT FROM QUARTERLY ECONOMIC REPORT
The Research Institute of America, Inc.
589 Fifth Avenue, New York, N.Y. 10017
(August 1, 1974)

The widely quoted "implicit price deflators" for the Gross National Product and its major components are not, unfortunately, price indexes at all. And, as seen in the chart below, they do not necessarily follow the same patterns and trends as do the recognized price indexes for the comparable segments of activity. There are three main reasons for this divergence, which it will pay to keep in mind when changes in the rate of rise or fall of the "deflators" are being discussed. First, as the term "implicit" indicates, the deflators are derived statistics, not direct, independent measures of price changes. Sec-



ond, the activities included in the various GNP segments do not match the coverages of the standard indexes of either retail or wholesale prices. And finally, the deflators do not measure the costs of standard bundles or "market baskets" of goods and services, but the costs of whatever goods and services are being consumed in the period being reported.

THE IMPLICIT PRICE DEFLATOR FOR CONSUMER EXPENDITURES, to use the example shown in our chart, is not computed directly as a price index, but is simply the ratio of the current-dollar value of these outlays to their calculated real-dollar value. And the real-dollar value itself, as explained further on pages 5 and 6, is not measured directly either, but is the result of a complex series of price-adjustment operations. The deflator, therefore, is at best an indirect, reconstituted "index of indexes," whose short-run fluctuations are not always understood by the analysts who prepare it, much less by the general public.

The differences between the coverages of the Consumer Price Index and the Consumer Expenditures Deflator are many. One important difference is that the CPI is intended to relate to the outlays of "urban wage earners and clerical employees," while the GNP figures refer to all consumers, and the two sets of spending patterns are certainly not the same. Again, many kinds of spending are treated differently in the two measures. Changes in such "prices" as home mortgage interest rates, for example, have very different effects on the CPI and the deflator. Thus, it would be surprising if the trends of the two series were, in fact, similar.

THE ABSENCE OF A FIXED MARKET-BASKET BASE for whatever it is that the GNP deflators measure is, particularly today, perhaps the most important single reason why these statistics should be handled with care as measures of inflation. Earlier this year, to take a dramatic example, consumers sharply reduced their automobile spending by buying fewer and smaller cars. The net effect of this on the consumer spending deflator was to tend to depress it, as high-priced auto outlays became a smaller factor in total spending. The CPI, on the other hand, continued to reflect the increases in automobile prices, regardless of the change in spending patterns. Similarly, any temporary change in consumers' standard of living affects the deflator, though it has no direct effect on the rate of inflation -- in fact, is more likely a result of inflation.

APPENDIX IV

HOSPITAL ASSOCIATION OF NEW YORK STATE
REVENUE CONTROL
UNDER THE NEW YORK STATE COST CONTROL LAW
AND
A PLAN FOR THE FUTURE

INTRODUCTION

Regulation of hospital revenue by New York State government is considered by many to be one of the most stringent systems in the country. Its intended effect is to reduce or "shrink" the health care system by withdrawal of funds from the system. Rather, it has caused mounting deficits in hospitals. For example, 153 of 230 surveyed in New York incurred net operating deficits in 1975.

The Hospital Association of New York State is convinced system curtailment can be accomplished through a more rational approach and has developed a plan to do so.

This document analyzes New York's fiscal controls and presents the Association's plan.

BACKGROUND

By Spring 1969, the cost of the Medicaid program in New York State had resulted in severe strains on the budgets of most counties as well as that of the state itself. Not only had there been underestimates of the utilization and the extent of the program but also there had been an escalation in hospital costs due mainly to catch-ups in wages and fringe benefits which account for over two-thirds of the costs. Unions, legalized in New York State since 1965, accounted for much of the pressure to increase wages.

The New York State Legislature reacted to these financial pressures by passing Chapter 957 of the Laws of New York of 1969, which has been referred to as the "Cost Control Law". Enacted on May 26, 1969, the law amended Section 2807 of Article 28 of the Public Health Law to:

1. Freeze Medicaid rates of payment in effect on March 31, 1969 until December 31, 1969 (subsequently declared unlawful).
2. Require that the Commissioner of Health certify to the Director of the Budget (for Medicaid rates) and to the Superintendent of Insurance (for Blue Cross rates) that proposed rate schedules were reasonably related to the costs of "efficient production" of hospital and health related services.
3. Require the Commissioner to consider economies and improvements to be anticipated from the operation of shared services or facilities and for alternatives to inpatient care.

4. Exclude costs for research, for educational salaries not directly related to hospital service, and allowances for costs not specifically identified.

Prospectivity and Part 86

The Cost Control Law did not mandate the prospective promulgation of reimbursement rates. Prospective reimbursement was required by the Commissioner of Health when he enacted his administrative rules and regulations to implement Chapter 957 (Official Compilation of Codes, Rules and Regulations of the State of New York, Title 10, Department of Health, Chapter II, Administrative Rules and Regulations, Subchapter K, Hospital and Related Facilities, Part 86, Reporting and Rate Certification for Medical Facilities).

While much emphasis has been placed on New York's "prospective rate" system, the facts indicate that rates were promulgated most frequently after the start of the rate period. Further these were not final rates but were subject to wholesale revisions due to reasons such as inadequate estimates of inflation. The legislature passed Chapter 682 of the Laws of 1974 requiring that the Commissioner of Health notify hospitals of their rates at least sixty (60) days prior to the start of their new rate year. This law was later repealed when it was found it could not be implemented by the Department.

Control Over Revenue by Formula

"Revenue control" is a more realistic name for the New York system. Over 50% of the revenues of the hospitals of the state are subject to the Part 86 rules (30% Blue Cross and 20% Medicaid). While the Department of Social Services (DSS) is the single state agency responsible under Federal law for the administration of the Medicaid Program (Title XIX) in New York State, the Department of Health fulfills the DSS rate-setting responsibilities as a subcontractor to DSS.

This interdepartmental relationship is in addition to those responsibilities of the Commissioner of Health under Section 2807 of the Public Health Law, as described earlier under Chapter 957, to certify Medicaid rates for approval by the Director of the Budget and Blue Cross rates for approval by the Superintendent of Insurance.

Effect on Blue Cross

In past years, the Commissioner of Health has allowed a considerable degree of flexibility in the reimbursement rate formula submitted by Blue Cross and Blue Shield of Greater New York for the lower seventeen (17) counties and by the Upstate Blue Cross Plans for the remainder of the state. He has recently struck a more rigid posture and has acted to require virtual identity between the provisions of the Blue Cross formulae and those used under Part 86 to compute Medicaid rates.

HOSPITAL ASSOCIATION OF NEW YORK STATE
REVENUE CONTROL UNDER THE NEW YORK STATE
COST CONTROL LAW AND A PLAN FOR THE FUTURE

Role of the State Hospital Review and Planning Council

This overview of New York's revenue controls should point out the statutory role of the State Hospital Review and Planning Council. Under the provisions of Section 2803 of the Public Health Law, the Council "... shall adopt and amend rules and regulations, subject to the approval of the Commissioner, to effectuate the provisions and purposes of this article ...". Until April 8, 1976 when the Commissioner of Health presented all of Part 86, including proposed amendments, to the Council for "adoption", the Commissioner had enacted rules and regulations in contravention of the statute. He modified his posture after receiving advice to do so from the Attorney General of New York State.

Part 86 and the New York State Title XIX Plan

Part 86 also serves as a methodology to calculate inpatient rates based on reasonable cost for Medicaid as required by Title XIX of the Social Security Law. Part 86 was approved by the Secretary of HEW in September 1971 as an alternate method of computing rates based on reasonable cost. The Part 86 formula is incorporated into the New York State Medicaid Plan as Attachment 4.19A.

A major problem with the administration of the State Plan has been that the Commissioner of Health has enacted changes to Part 86 over the years and the Department of Social Services has paid Medicaid rates reflecting these plan amendments without having obtained the prior approval of the Secretary of HEW as required by Federal law. There has been a consistent history of violation of the prior approval requirement. It was not until August 16, 1976, when the Regional Commissioner approved State Plan amendments followed by the order of a Federal court, that New York State adjusted rates retroactively to compensate hospitals for underpayments from January 1 through August 15, 1976 and that the statute was honored.

How the Revenue Control Formula Works

The basic premises which underlie New York's revenue control formula set forth in Part 86 are that the Department of Health controls franchising, construction, addition and deletion of services, etc. Thus it can be presumed that a hospital should not experience substantive changes from year to year which should effect its costs except for changes in the prices of goods and services it must purchase (inflation). A hospital files a cost report called the Uniform Financial Report (UFR) and a statistical report called the Uniform Statistical Report (USR) by May 1 of the year following the end of the mandated calendar fiscal year. The UFR and the USR constitute the rate base data for the computation of rates for two years hence (rate year).

HOSPITAL ASSOCIATION OF NEW YORK STATE
REVENUE CONTROL UNDER THE NEW YORK STATE
COST CONTROL LAW AND A PLAN FOR THE FUTURE

Allocation of Costs

Costs on the UFR are allocated to inpatient, emergency service, clinics, research, etc., in the same general manner prescribed under the Medicare principles of reimbursement for Form SSA 2552. The costs are stepped-down to the various revenue centers but the allocation is not based on utilization as required for Medicare using the RCC/AC method. New York's formula bases allowable costs on average costs and can result in variances of two to three percent between different classes of payor from one hospital to another.

Allowable Cost Ceilings

Hospitals are grouped according to a number of characteristics using a mathematical technique which is supposed to result in peer groupings. The routine care costs and the ancillary services costs of the hospitals in each group are separately arrayed. Routine costs per day and ancillary costs per discharge are calculated for each hospital and for the group. Hospital unit costs which are either under 75% or over 125% of the group average are excluded and a new group average is struck. All costs of each hospital in excess of the new group average are disallowed. Therefore, they are subtracted from the rate base and the hospital loses the opportunity to recoup these expenditures unless they are able to file a successful appeal.

A second and different method is used to develop yet another "peer" group of hospitals for a length of stay (LOS) test. The average LOS for each hospital in the group as well as the group average is computed. Those under 75% and over 125% are again excluded and a new group average is struck. Days in the LOS of any hospital in excess of this new group average LOS are disallowed. The value of the days times the hospital's per diem routine care cost is subtracted from the rate base and the hospital loses the opportunity to recoup these expenditures unless they are able to file a successful appeal. At this writing, the possibility exists that this could be modified by the State Hospital Review and Planning Council.

Inflation Rate

The Department of Health determined the trend factors which are its estimate of inflation from the base year to the rate year. Since the state is the purchaser of services and also sets the rates, it has an obvious conflict of interest. This conflict of interest has been evidenced in recent years when inflation estimates knowingly were pegged grossly low despite strong evidence to the contrary. Later in the year, the state had to revise its rates and make retroactive payments because of these underestimates.

Utilization Penalties

The formula also contains provisions which penalize hospitals if volume levels in specified services and procedures were not attained in the base year. These penalties result in "imputing" or adding hypothetical days to the actual days

of service rendered by the hospital. The inflated total is divided into allowable trended costs to determine the prospective rate. By imputing days, the total days denominator is increased while the allowable trended costs amount remains unchanged so that the resultant per diem rate is lower than that which might have been based only on actual days of service.

Disallowed Costs

Other costs are also not allowable under the New York formula. Examples include but are not limited to: bad debts, 10% of salaries and fringe benefits paid to interns and residents, unfunded depreciation, interest expense to the extent of unrestricted income on endowments, etc. To this list must be added those costs specified as non-allowable under the Medicare principles of reimbursement.

A limit was added to the formula in 1976. It forever limits allowable costs in future years to 1975 allowable costs times the inflation factor used by the state to trend the 1975 allowable costs into 1976. Only amounts approved on appeals in the rate year may be added to the limit. Thus, a hospital whose costs might be disallowed under any of the provisions of the formula stands to lose those funds without any hope of ever recovering them.

Due Process

New York's system fails to provide adequate provisions for due process. The criteria for appeals are too restrictive and are not adequately described. There are no time limits or procedures set forth in Part 86. Hospitals have not gotten timely answers to their filings.

A Responsible Alternative

The Congress has prescribed a course of planning and regulation of health care resources under PL 93-641. HANYS has proposed a plan to forge a co-operative bond between providers, payors, regulators, planners, and consumers to work to contain the inexorable increases in the costs of meeting the health care needs of every citizen while preserving existing resources and working for a better delivery system in the future.

Such a plan depends upon mutual respect, upon due process, upon the collection of relevant facts, upon the development of practical and achievable standards, and upon the willingness to combine tough-mindedness with fair-mindedness. Hospitals must close. People must change jobs. Communities must adjust. But this revolution must occur in a constructive climate consistent with our basic beliefs in individual dignity.

Attached is the Association sponsored plan titled Statement for Provision of Health Services to the Citizens of New York State.

REPORT OF THE TASK FORCE ON REGULATION

HOSPITAL ASSOCIATION OF NEW YORK STATE • 15 COMPUTER DRIVE WEST ALBANY, NEW YORK 12205



REPORT

of the

TASK FORCE ON REGULATION

Hospital Association of New York State
15 Computer Drive West
Albany, New York 12205

1976

INTRODUCTION

Data from this Report indicate 164 different regulatory agencies have some jurisdiction over hospitals in New York State. The Report discusses duplication of effort by these agencies and presents examples of unreasonable actions by regulatory officials.

Government has the right to regulate; this is accepted. It is inconceivable to accept the necessity for 164 different agencies.

Could any rational person accept the need for 25 separate agencies to review hospital admitting procedures? Does it take 33 agencies to protect patients' rights? Or, does it take 31 agencies to assure patient safety?

Our recommendations for improvement are presented at the beginning of this Report.

CONTENTS

I	Recommendations	1
II	Background	3
III	Objectives	4
IV	The New Emphasis on Government Regulation of Hospitals	5
V	Task Force on Regulation General Accounting Office Study	7
VI	Regulation of Hospitals — Once, Twice, Or Even a Hundred Times	8
VII	The Bureaucracy at Work	10
VIII	Some Principles That Would Help	14

Appendices

A.	HANYS/GAO Survey Highlights	21
B.	Methodology/Findings	22
C.	Task Force Roster	51
D.	Task Force Subcommittee	52
E.	Agencies Identified	53

95-195 O - 77 - pt. 2 - 27

REPORT
TASK FORCE ON REGULATION

The Task Force on Regulation has met six times since the 1975 Annual Membership Meeting, undertaken an in-depth study of duplicative regulatory operations in eight hospitals, and spent many hours studying and commenting on the drafts of this report.

I. RECOMMENDATIONS

1. The federal government should move expeditiously to develop a national health policy to be administered in a more systematic and reasonable fashion through a reorganization and consolidation of activities. This could be accomplished through the creation of a Cabinet level Department of Health as the administrative agency to coordinate all federal health programs.
2. The federal Department of Health, Education and Welfare should review the policies and procedures of the 25 separate units within the Department that affect hospitals and coordinate these activities to eliminate the prevalent fragmentation and duplication in hospital regulation.
3. The State should establish an objective State Health Services Commission free from present conflicts of interest.
4. The State Health Services Commission should develop a state health policy, including reasonableness of regulation as one significant part of this policy.
5. The Commission should take every reasonable effort to eliminate costly duplicative regulations.
6. Utilization review activities should be directed by the Professional Standards Review Organizations rather than be duplicated by state actions such as the costly network of on-site reviewers.
7. Due process must be recognized as a component of all state regulatory operations. Rulemaking should include (1) prior notice with adequate time for all interested parties to comment before implementation, preferably at a public hearing, (2) fair opportunity for administrative appeals to be heard when adverse decisions are made against hospitals and other providers, and (3) publication of proposed rules, comments, hearings, decisions, and other matters of general interest including the list of hearing officers. When an adverse decision has been rendered, there should be specific reasons for the decision, full disclosure of the appeal mechanism, a timely hearing schedule, proper conduct of the hearing, and the findings should be made known within a reasonable amount of time. It is expected that the Administrative Procedures Act, properly implemented, will be a major factor in improving due process throughout New York State's regulatory process.
8. There should be an immediate study, by both hospital and state representatives, to seek appropriate objectives and standards for what constitutes an *acceptable* level of care.
9. Legislation should be enacted giving the Legislature veto power over Executive regulations which exceed Legislative intent.

10. All regulations mandated by the State should include an economic impact statement, from the agency issuing the regulation, stating how much money implementation of the regulations would cost the regulated and how the State expects these costs to be reimbursed. At appropriate intervals, the actual economic impact should be evaluated and announced.
11. All state regulations should be subject to regular review for assurance of continued relevancy and to confirm that the need for the regulation still exists.
12. Regulatory lag should be eliminated through planning on implementation of legislation rather than last minute development of regulations, or even worse, the development of regulations in haste, after the effective date of the legislation. When regulations are promulgated, they should be complete and not presented with a series of amendments and corrections.
13. Reimbursement appeals should be processed within one month after they are submitted and a formal and equitable appeals process should be operational in the Department.

This Association and our member institutions want to cooperate with the State and the Legislature in bringing these recommendations into practice.

II. BACKGROUND

At the Hospital Association of New York State's Annual Membership Conference in October 1975, hospital administrators and other hospital representatives forcefully expressed their concern and frustration with increasing government regulation. The magnitude and complexity of government regulation had been increasing at an enormous rate and the paperwork associated with it consumed more and more scarce resources and management time and talent. It was strongly felt the regulating agencies were duplicating one another's work and many of the regulations were counterproductive.

At a time when government was critical of rising health care costs, hospitals were subjected to a constant barrage of increased inspections and new regulations some of which added costs to hospital operations with little or no demonstrable benefit to patient care.

HANYS membership passed this resolution calling for a report on government regulation:

> *"Be it resolved that HANYS establish a task force to include governing board members, hospital administrators, and auxilians from throughout all areas of the State and representing hospitals of all sizes to develop a recommended strategy for forcefully advising government and the public of the consequences of curtailment of services resulting from the regulatory mandates imposed by the Health Department of New York State and other regulatory agencies. Such a strategy could also include the development of costs which could be saved through elimination of regulations without effect on quality of care."*

When the state administration first proposed Medicaid cutbacks in December 1975, HANYS responded by urging that reductions be accomplished through ending government mismanagement of the Medicaid program and by establishment of a Blue Ribbon Panel to find ways of cutting hospital costs by eliminating counterproductive regulations. The Legislature has not acted on the Blue Ribbon Panel recommendation but HANYS formed its own Task Force to carry out the membership's intent: the Task Force on Regulation.

III. OBJECTIVES

This report does not suggest the elimination of all government regulation but rather urges a reasonable regulatory process:

- which is systematically administered rather than fragmented and duplicative,
- where the regulation provides significant benefits to patients,
- which includes input from affected parties,
- which yields clear and understandably written regulations,
- which provides the funds to support the implementation of government-mandated requirements,
- which has appeal mechanisms for those affected, and
- which requires a concurrent economic statement on cost to the health care delivery system resulting from the proposed regulation.

IV. THE NEW EMPHASIS ON GOVERNMENT REGULATION OF HOSPITALS

Hospitals have long been regulated by government agencies but most of the regulatory activities directed exclusively toward the industry have been initiated relatively recently — beginning, for the most part, in the 1960's with the tempo accelerating in the 1970's.

States historically have exercised a regulatory role involving building codes. The other significant involvement of state and federal governments was the Hill-Burton program which began in 1946.

It was the advent of Medicare, Medicaid and Article 28 of the New York State Public Health Law, late in the 1960's, that brought government agencies into hospitals on a continuous basis. Traditional areas such as fire safety and construction codes remained but New York hospitals found themselves regulated in purely medical areas such as the amounts and types of services offered, length of patient stay and appropriateness of admission and treatment.

A 1973 State Health Department publication, *The Article 28 Story*, states:

> *"The Department sets standards and exercises the right of regular inspection, audit and review over every aspect of health facility planning, construction, and operation. In effect, without Health Department approval, new facilities may not be established and existing facilities may not continue to operate in New York State."*

While health care is important enough to be regulated for social reasons, there is a pronounced relationship between the amount of government dollars flowing into the health system and the amount of government regulation. It is common knowledge in health as well as in other industries that government dollars inevitably are accompanied by government *strings*. This is exactly what has happened in New York State with the State Health Department playing the major role in setting reimbursement rates and, concurrently as the primary regulatory agency, steadily expanding its activities in that area. At present, more than 50% of the revenues of New York's hospitals are from government sources; another 30% (Blue Cross) are controlled by government.

In 1964 the New York State Department of Health had about 2,000 employees, exclusive of institutional employees. By 1970, the Department had grown to about 3,000 and in 1973, the number was only slightly higher — still less than 3,100. In 1975, the number increased to over 3,500, exclusive of institutions.

While the increase in number of employees has been dramatic in the last decade, it does not tell the whole story. In addition to increasing numbers, the employee mix changed drastically away from traditional public health positions to regulatory and fiscal planning assignments.

In a public hearing on August 18, 1976, the Commissioner of Health said "... the major focus of the Department has been directed at streamlining and beefing up our enforcement activities ...." In talking about the change in the employee mix at the Health Department, the Commissioner added, "Obviously, changes and evaluations must be made when you go from an audit bureau with 45

auditor positions as of January 1, 1975 to 170 positions less than two years later."

Some of the other employee changes mentioned in that public hearing support the Task Force citation about the change in the Department's emphasis from health to regulation:

Staffing, Selected Positions, New York State DOH

	1965	1976	change
Accountants	2	170	+8,500%
Attorneys	3	30	+1,000%
Physicians	69	60	- 13%

The vast majority of jobs in the State Health Department are now related to regulatory activities and in the State's 1976-77 austerity budget there is provision for 568 new regulatory positions.

The Health Department's regulatory staff is larger than the entire staff of the State Banking Department, or State Insurance Department or the Public Service Commission. When considered in conjunction with the numerous other federal, state and local agencies regulating hospitals, it is apparent the hospital industry may well be the most heavily regulated in the State.

V. TASK FORCE ON REGULATION — GENERAL ACCOUNTING OFFICE STUDY

A joint Task Force on Regulation/U.S. General Accounting Office study on Medicaid regulation reveals the extent of the problem from the perspective of the hospitals. Two hundred and ten member hospitals answered a questionnaire on administration of the Medicaid program.

A significant 29% of the responses indicated federal laws and regulations constituted a "substantial" or "great" problem.

An overwhelming 88% of the hospitals called state laws and regulations a "substantial" or "great problem."

Only 2% of the hospitals saw state laws and regulations as no problem while another 8% saw the problem as "minor" or "moderate".

Thus, about nine out of ten New York State voluntary and public hospitals view State laws and regulations as creating difficult problems. This extremely high percentage is indication that something has gone awry in the New York State regulatory process.

(A summary of responses is included as Appendix A.)

VI. THE REGULATION OF HOSPITALS — ONCE, TWICE . . . OR EVEN A HUNDRED TIMES

No individual nor enterprise is without regulation; rules and regulations are necessary to insure the orderly functioning of society while protecting and respecting individual prerogatives.

The Task Force is not opposed to regulation but the comments of the membership and the experiences of the individual members of the Task Force made it apparent that regulation of hospitals in New York has become a costly and onerous burden.

It was accepted as fact that hospitals are over regulated but there was nothing to substantiate this commonly accepted belief. Early in its deliberations, the Task Force recognized that a broad base of factual information would be essential; statements about over regulation needed substantiation. If the work of the Task Force was to have any impact on Legislators, business and labor leaders and the general public, it had to be based on more than opinion. Objectively collected and analyzed data would provide the credibility and acceptance needed to substantiate our beliefs.

Collecting information about the regulation of hospitals was a major task. Hospitals are complex entities, providing services to every segment of our society in all parts of the State. Each resident of the State is affected by the hospitals in New York both personally and financially. The finances involve not only the individual's personal payments for health insurance or medical services but also his role as taxpayer.

Because of the complexity of services and the multiple sources of hospital income, almost every department in a hospital is subject to regulation in some form. The bewildering variety of agencies and the highly specialized nature of many hospital activities made it impossible for any administrator to keep track of all the inspectors and regulators demanding reports from his institution. The Task Force was unable to locate any source or authority with an inventory of all the different regulations and regulators affecting hospital activities.

Despite the lack of a ready source for this information, the Task Force felt strongly that such an inventory was needed, and an Ad Hoc Subcommittee was formed to develop a matrix format to identify each matter or activity subject to regulation and, further, to identify the body or agency enforcing the regulation. (The methodologies and inventory summaries are in Appendix B.)

The inventory data indicated a total of 164 different regulatory bodies involved with hospitals in New York State:

	Number		Percent	
State agencies	96	136	59	83%
Federal agencies	40		24	
City and County agencies	18		11	
Voluntary and Quasi public agencies	10		6	
	164		100%	

This amounts to something less than one regulatory contact each working day. One a day doesn't appear to be an overwhelming burden, but the lack of coordination and the duplication of the same inspections and reports is a legitimate and realistic problem for hospital administrators.

It is inconceivable to accept that 164 different agencies are needed to assure patient safety and approve of patient health care. And this is the case, many of the regulations and regulatory agencies are interested in matters other than the care of the patient.

An analysis of the individual matters regulated by the most different regulatory bodies indicates the greatest regulatory concern seems directed at administrative services (admin.) and financial and information services (fin. & info.). The five matters regulated by the largest number of different bodies were:

Matter and Major Area	# of Different Bodies
Policies, Procedures and Organization (admin.)	67
Standards of Performance (admin.)	59
Professional Standards (admin.)	53
Accounting and Recording (fin. & info.)	51
Financial and Statistical Reporting (fin. & info.)	51

The single most frequent matter subject to scrutiny by various agencies was Policies, Procedures and Organization (admin.) which involved reporting to 67 different agencies.

Other than the voluntary agency, JCAH, these were the five most frequently cited agencies:

Agency	#of Matters Regulated
City and County Health Departments	64
State Health Department (NYSDH):	
Bureau of Hospital Nursing Service	51
Bureau of Nutrition	48
DHEW — Office of Professional Standards Review	48
NYSDH — Bureau of Hospital Certification	45

The variety and number of agencies involved in the regulatory process is obvious. It is equally obvious the focus of agency concern is paperwork, administration and finance rather than direct patient care.

Duplication of agency efforts and fragmentation of inspections are alluded too often during this report. In the matrix inventory, 109 different matters were identified as the subject of scrutiny by 164 different agencies. Analysis of the matrix inventory shows that 82 of the 109 matters were cited as subject to the scrutiny of at least 10 different bodies.

Hospitals with their history of care for the injured and sick are certainly acutely sensitive to human rights. Still, the need for some regulation could be accepted. However, it is difficult to comprehend why 33 different agencies are involved in reports and inspections on patients' rights. When the right of government to regulate is accepted, there is still a problem in working with 33 different agencies of which 15 are state agencies. Logic argues that a single agency could collect and share the necessary data.

Why does it take 25 separate agencies, 14 state agencies, five federal agencies and an additional six local and voluntary agencies to review admitting procedures? In 1975 hospitals in New York State recorded 2.8 million admissions and each was apparently subject to scrutiny by a plethora of regulatory bodies.

VII. THE BUREAUCRACY AT WORK

The examples in the next few pages probably do more to explain the frustrations of bureaucratic mismanagement than would volumes of objective statistical analysis. The Task Force believes that incidents reported by individual hospitals are indicative of similar treatment of all hospitals, and inherent in New York's regulatory process.

A Comment By a Judge

Because with increased frequency, appeals to the Health Department end in litigation, it is appropriate to open this section with an opinion on the interpretation of Health Department regulations from a State Supreme Court Justice. Justice Henry Hudson of the Supreme Court of New York, County of Onondaga, made this comment about the Health Department's reimbursement regulation relating to appeals [86.17(b)]:

> *"At this point, it would be appropriate to observe the working of the rules is of such a general and vague nature that they would be susceptible to many and varied interpretations as to their exact meaning. . . . After reading the rules through in an effort to understand their meaning at least ten times, I do not feel that it is possible to state with any certainty in what manner many of the separately numbered sections should, or could, be interpreted."* 8/20/75

Comments from an Administrator

After working as the chief executive officer of a hospital in Binghamton for slightly more than six months, William Christenson resigned in December of 1975 and relocated to Massachusetts which, he said, *". . . seems to be more rational than New York. There seems to be less power in the hands of that state's health department."*

In discussing his resignation with the hospital's Board of Managers, he remarked the prospect of pressures by the New York State Health Department was a major factor in his decision to seek a new job outside the state, and added, "New York is absolutely the worst state in the country to be a hospital administrator." (Binghamton **Sun Bulletin,** *December 1975)*

Article 28 and Typewriters

Under Article 28, purchases in excess of $100,000 and purchases which affect patient care must be approved by the Health Department. In a June 24, 1976 letter from a Regional Office of the State Health Department, an upstate hospital learned the Health Department must also approve the purchase of routine office equipment such as typewriters. The Health Department said:

> *"I don't think we can prejudge these factors until at least we have the facts before use (sic) to evaluate. For example, the purchase and/or replacement of a typewriter or microscope, these items would not require Article 28 approval because neither would be involving adding a new service, cost would be minimal, there are no direct patient safety involvements and these would not represent added or expanded technology. However, if the facility does decide to purchase and/or replace ten typewriters at a cost of $5,000 this cost would be subject to review as having a considerable influence on the per diem rate should these purchases be from patient generated revenue."*

The "considerable influence" mentioned in the letter from the Health Department amounts to 7/100 of 1% of this hospital's operating budget for a year. The amount is not the main issue; Health Department intrusion into normal business operations, as evidenced by the letter is most certainly the primary problem.

An Exchange of Correspondence

Most correspondence with Health Department offices seems to close with statements such as "don't hesitate to call" or "if we can help, please call." Although this is courteous, it doesn't seem to be very effective. A summary of correspondence between one financially beleagured hospital and the State's Bureau of Health Facility Financing went something like this:

January 20 — The hospital wrote the Health Department telling of its inability to deposit to an escrow fund. The hospital's reimbursement rates, mandated by another bureau of the Health Department were insufficient to meet the hospital's cost of operation.

February 10 — The Health Department responded with sympathy.

March 8 — The Health Department asked the hospital why it was projecting an operating deficit of $336,100.

March 11 — The hospital said the causes were frozen Blue Cross and Medicaid rates, and increasing costs, beyond their control.

April 5 — The Department said the problems were similar to those faced by other institutions.

April 20 —The hospital said the State's freeze was the cause of the problem: "If we are to run our hospital based upon the State's ability to pay their bills, our problems have just begun."

That apparently ended the correspondence between that hospital and the Health Department but about three months later, the Bureau of Health Facility Planning sent a notice to all hospitals with funding from the State-sponsored mortgage program, 28B:

> *"If expenses will exceed revenues, costs must be reduced. If expenses will increase because of salary increases, utility costs or any other reasons, offsetting reductions in costs must be obtained by revising operations or reducing non-code services."*

A notice such as this seems reasonable and straightforward when read, but there are other factors involved. Under 86.31, another reimbursement regulation from the State, a hospital is required to report reductions in services or changes in operations which result in a reduction in costs. The Health Department then reduces the reimbursement rate to reflect the lowered costs. This could start the cycle all over because, once again, the reduction in revenues may mean expenses will exceed revenues.

Some Counterproductive Regulations

A local fire department in a Long Island community requires New York City standard threads on all fire hoses. The county fire department requires another, incompatible, system: National Standard threads on all fire hoses.

The county fire commission requires monthly inspections of the fire alarm system and the county health department requires weekly inspections.

PSRO agencies, the newly formed, federally-mandated physician review programs want data based on maximum length of stay statistics by disease, age and other factors. Other federal agencies require additional, and different data with justification for the continued stay of the patient at 12, 18 and 30 day intervals.

State regulations permit microfilming of some patient records but the hospital must retain the originals.

The plans for a new hospital building were approved by the central Health Department offices in Albany. The regional office surveyors cited the hospital for non-compliance, after the State Health Department's central office approval of the facility.

Under Article 28, all new construction must be approved by the Health Department prior to starting the building and at numerous points during construction. The approval procedures include exhaustive analysis of the building plans and numerous on-site visits. A new facility in Central New York was in full compliance with all the local, federal and state regulations before and throughout the construction period; comments from the federal government dating back five years were included in the building plans. As required by state law, there was an inspection when the building was almost completed, about 8 weeks before occupancy.

The inspection was held February 25. The inspector's report was dated 5 weeks later, April 2 which was three weeks before occupancy. This report listed a number of violations which required considerable additional construction.

All of the indicated violations were apparent on the plans and should have been noted by inspectors some time during the 5-year period of planning and construction but notification of violation did not take place until 3 weeks before the building was scheduled for use.

Duplication x 3 Equals Fragmentation

In addition to its general, acute care beds, a hospital in a small Upstate town has three chronic care facilities as part of the institution. The hospital's laundry, dietary units and many other support programs provide their services to the long term care facilities as well as to the acute care part of the hospital. For all practical purposes, it is one, cohesive unit. But not as far as the regulators are concerned.

Surveys and reports for each of the chronic care facilities must be handled individually. The Health Department recently conducted a survey which encompassed both federal and state code compliance. Six separate reports were presented to the hospital, with considerable overlap in areas of alleged non-compliance.

The lack of an in-service training program in Dietary was cited six times. Six separate plans of correction were required. Because there is only one dietary department for the complex, the *same* plan was repeated six times. The administrator of this institution feels this type of blind compliance with regulatory protocol is utterly without reason, and inflationary.

A Final Frustration

Under state regulations, a hospital may suffer a fiscal sanction for providing an unacceptable level of care. The term fiscal sanction is governmentese for financial punishment, fines. The Health Department can levy a 10% reduction in a

hospital's Medicaid and Blue Cross rates if it is said to be providing an unacceptable level of care, an example of the negative incentives promulgated by the State Department of Health.

The State's retaliatory powers, through punitive financial measures, may apparently be exercised with great freedom, almost abandon. One of the primary difficulties lies with the method, or lack of method, the State uses to decide that a particular institution is providing an unacceptable level of care.

The case of the first hospital to face the 10% reduction reveals the Health Department methods and provides some insight into the bureaucratic morass hospitals must face.

This particular institution was surveyed in August, 1975. The surveyor pointed out, among other matters, that the hospital's PAP smear program was not meeting State requirements. Ten months later, the Department informed the hospital it was subject to a 10% reduction in Medicaid and Blue Cross payments because it was providing an unacceptable level of care.

On the face of it, some action was indicated. The hospital was reported as providing an unacceptable level of care and was going to be fined. What the Health Department overlooked was the passage of time and the concurrent improvement in that institution's PAP smear program.

On May 5, 1976, the Cancer Control Bureau of the State Health Department wrote to the hospital about the PAP smear program which the Bureau had just analyzed. (This letter went out about six weeks before the letter censuring the hospital for inadequate PAP tests). The May 5 letter said:

> *"The results of analysis indicate that your institution with a compliance rate of 100% is in good compliance to the code requirement. On behalf of the New York State Department of Health may I congratulate you and your medical staff for your efforts in screening women inpatients for Cervical Cancer."*

To further aggravate the problem, the regulation under which the hospital was to be fined did not go into effect until six weeks *after* the August survey was made. The hospital wasn't informed of the problem and, more critically, the State Hospital Review and Planning Council was asked to make a determination about this hospital without full information. *Approximately six weeks after the hospital had been congratulated on the excellence of its PAP program, the Council was told the hospital did not perform PAP smears.*

Under the regulations in existence at the time this hospital was notified of the reduction in reimbursement, there was no mechanism for appeal. The only recourse for the hospital was costly and time-consuming litigation. However, the federal Department of Health, Education and Welfare now has entered the picture and has indicated that it will require the State to institute a hearing process in the implementation of this regulation.

VIII. SOME PRINCIPLES THAT WOULD HELP

The Task Force believes that the following principles, when converted to action, would bring some sense of order and reasonableness to the chaotic existing situation:

A. Promote an end to the fragmentation of health policies at the federal and state levels of government

B. Consolidate inspections and audits

C. Coordinate Utilization Review under PSROs rather than duplicative State on-site reviewers

D. Establish an objective decision making body to regulate health facilities

E. Develop rational standards for audits and surveys

F. Assure due process in all matters relating to hospital operations

G. Reduce regulatory lag

A. The fragmentation of health policy at federal and state levels should be ended.

The in-depth study of 8 hospitals (Appendix B) demonstrates the number of federal departments and agencies involved in the regulation of hospitals. In addition, there are 25 separate units within the Department of Health, Education and Welfare that affect hospitals. Yet there is no single health policy at the federal level or any means available to coordinate the policies of the various federal governmental agencies regulating health care. Some health administrators are of the opinion that the federal government is the appropriate level to conduct regulatory health activities. This approach may or may not be the best for ending the duplication of regulatory activity that exists among levels of government but it is a question that could be considered.

The situation is equally chaotic at the state level which adds to the anarchy of governmental health policy. Not only do 96 state agencies regulate hospitals, but other state bodies in the health policy area include the:

Health Planning Commission
Health Advisory Council
Public Health Council
State Hospital Review and Planning Council
Statewide Health Coordinating Council
Health Research Council
Medicaid Advisory Council

There are also councils in the mental hygiene area and a plethora of advisory committees to the State Health Commissioner. This morass at the federal and state levels forces the burden of coordinating governmental regulators upon the hospital administrator. The administrator has to try and make sense of innumerable governmental directives and judgments that flow, uncoordinated and increasingly from the desks of bureaucrats in Washington, Albany and a myriad of federal and state regional offices.

New York's Health Systems Agencies have replaced the old duplicative health planning efforts in New York State and have the *potential* to bring about coordination of the health delivery system within the State. However, it is too early to know if this potential will be realized.

B. There Should Be A Consolidation of Inspections and Audits.

With some 160 bodies overseeing more than 100 separate matters, it is logical that many of these inspections should be consolidated and that, properly coordinated, most inspections could be undertaken at one time. This would result in administrators and other hospital personnel saving enormous amounts of time that could be used more profitably in other pursuits.

It would save millions of taxpayer dollars and alleviate the present aggravating system which seems to generate an endless flow of inspection teams. For example, the inspections conducted by the Joint Commission on Accreditation of Hospitals are similar, although not identical, to those performed by the New York State Department of Health. Inspections by JCAH are comprehensive evaluations of each aspect of hospital operation. Inspecting teams from this respected national organization are on-site in a hospital for three or four days. The fullness and effectiveness of these surveys is recognized by DHEW which accepts JCAH accreditation, with the results of JCAH surveys and reports maintained on a confidential basis, as presumptive evidence of a hospital's eligibility to receive Medicare patients.

If JCAH standards are acceptable for Medicare, it would seem logical to accept them for Medicaid as well. But, as is often the case in the tangled morass of regulations known as the New York State Hospital Code, there is no place for logic. The New York State Department of Health also requires a comprehensive inspection. This Article 28 Inspection also lasts several days and also requires an investigative team.

JCAH has earned an excellent reputation for efficiency and fairness. Accreditation by this group is a prerequisite for membership in many organizations, including HANYS.

The Task Force strongly recommends that the New York State Department of Health accept JCAH inspection survey reports in lieu of Article 28 inspections, on the same basis as does the federal government for Medicare purposes. This would eliminate a multiplicity of costly inspection systems.

The result of an inspection by a state team may be a fine or fiscal sanction. The result of an inspection by a JCAH team will be the correction of the problem.

If the purpose of inspection is punishment, the state team should continue to enforce. If the purpose of the inspection is the correction of problems, and improvement of patient care, there is little question but that JCAH should serve as the inspecting organization.

C. Utilization Review should be coordinated — with PSROs serving as the primary utilization review agencies.

The entire utilization review area is clouded with duplication and uncertainty. Some of those involved are the New York State Hospital Utilization Reiew data system operated by the New York State Health Department, State Health Department on-site utilization reviewers, and PSROs (Professional Standards Review Organizations) formed under the auspices of HEW.

New York State is spending from $2.5 to $3 million on an on-site utilization review program that will duplicate work being done by PSROs in the same area. Mrs. Bernice Bernstein, Director of HEW's Region 2, wrote Governor Carey in March, 1976:

> *"Specifically, the [proposed state law] could vest final review authority in the State Commissioner of Health over determinations of medical necessity and appropriateness of services provided under Medicaid,*

where a PSRO has assumed such authority with the approval of the Secretary of the Department of Health, Education and Welfare. In the latter instance, the PSRO Act clearly provides that such determinations are to be conclusively made by the PSRO; no payment of Federal funds. may be made where the PSRO disapproves of such services subject to its review, and so notifies the paying agency. Furthermore, section 1164 of the Social Security Act requires the application of the provisions of that Act to the operation of a state's Medicaid plan or program.

"Although the initial designations of PSROs are to be on a conditional basis, the Secretary has determined that, during the conditional phase, PSRO review of medical necessity and appropriateness to be final. Accordingly, determinations of medical necessity by the State must be subordinated in any case under the jurisdiction of the PSRO.

"If authoritative state review were to be imposed together with PSRO review, questions could be raised of compliance with section 1164, and of Federal reimbursement of duplication of review since the Secretary has also determined that federal funding for parallel review activities shall be disallowed."

Similar sentiments were expressed in a September 1976 HEW memo from Washington to all state medicaid agencies. Still, in a so-called austerity year, New York State seems determined to spend taxpayer's money to do exactly what the PSROs are doing.

D. A Health Services Commission is Needed

The State Health Commissioner at present has an inordinate amount of power and is in a conflict of interest position. The State Health Commissioner is primarily responsible for computing Medicaid reimbursement rates, influencing Blue Cross rates, determining what facilities will be built and where, deciding what equipment and services will be added to hospital operations, inspecting hospitals, and collecting vast amounts of data. The State is also a major purchaser of medical services, under the Medicaid program. This places the Commissioner of Health in the enviable but conflicting position of establishing the rates the State will pay for services it purchases.

The result is an inordinate amount of power concentrated in the hands of one individual. Such unbridled power, combined with the recent trend of promulgating punitive regulations that are not accompanied by due process procedures, makes the need for a Health Services Commission imperative. Such a Commission should consist of a body of qualified decision-makers responsive to the needs of all New Yorkers. The Commission, while regulating hospitals, would not at the same time be a purchaser of health care.

This approach would preclude the potential of one individual having the authority to force his will on the entire health system of the state and assure objectivity in the regulation — including reimbursement to the state's health facilities.

95-195 O - 77 - pt. 2 - 28

E. The State needs to develop rational survey standards to set forth the objectives of inspections of the quality of care provided by hospitals.

At present, the State Health Department sends scores of inspectors from its six regional offices into hospitals and other health facilities. The State does not provide these inspectors with clearly defined objectives which would result in uniform standards for what constitutes an acceptable — or an unacceptable — level of care. Determinations vary from region to region and from inspector to inspector. Too often the emphasis is on *paperwork* and *not on patient care.*

The Moreland Commission on Nursing Homes recently reached a conclusion that is equally applicable to hospitals:

> *"The Health Department — and also, it should be noted, the Department of Health, Education and Welfare at the federal level — have not developed sensible and workable regulatory programs. They have not even taken the essential first steps, which are to determine what is important to regulate in nursing homes, and how to measure what is important. Instead, regulation has been piled on regulation in bewildering detail, with little attempt made to determine which is essential and which superfluous.*

> *"Nursing home regulators have never developed explicit definitions of acceptable care, have not devised instruments to measure whether care rendered in homes is acceptable and have not been able to formulate refined tactics and strategies to enforce acceptable care standards. Thus, for example, in survey inspection efforts of the Health Department, altogether too much attention is placed on items that are immediately measureable — whether facility personnel hold the right qualifications, whether staff ratios meet code standards, whether myriad forms of paperwork are completed and properly signed, and whether facilities meet provisions of the Hospital Code with respect to corridor widths, room size and many other structural requirements.* None of these capture what is essential: whether care rendered is acceptable or not. *Over 500 items must be completed by department inspection teams using a federally mandated survey form; only 30 of these items might require direct patient observation. Countless hours of inspection time will be absorbed using recently revised inspection protocols for nursing homes developed by the department, now 166 pages long. The Commission fails to see how this activity will either measure or improve patient care."*

Still, the State Health Department assesses financial penalties on hospitals it finds are providing an unacceptable level of care — despite the lack of a set of standards to control the resulting subjective judgments of its legions of inspectors.

A June, 1976 letter from the Department's central office to its regional offices said:

"As you know, the recently amended Part 86 provides for an adjustment to the hospital rate whenever there are documented findings of an unacceptable level of care. The Commissioner's Rules and Regulations 86.17(g), as attached, further authorizes the State Hospital Review and Planning Council to review the Article 28 survey findings and determine whether these findings constitute an unacceptable level of care. Such a determination by the Council calls for a 10% reduction in the Medicaid and Blue Cross reimbursement rate of the hospital. This recent amendment to Part 86 provides additional enforcement powers to each regional office in order to bring their "problem hospitals" into compliance without the time consuming hearing process."

The letter then cited specific provision of the Code which would be indicative of an unacceptable level of care, but the Hospital Code (as now constituted) is not a document which can be construed to contain uniform standards.

The elimination of "time consuming" hearings would probably provide a welcome relief for the bureaucracy. But this elimination of due process in such an off-hand manner is appalling and contrary to the democratic system as we have come to know it.

F. Punitive regulations should not be implemented without due process.

Punitive regulations such as reducing reimbursement rates for an unacceptable level of care should not be implemented without due process. For example, the first hospital to be penalized under the regulation 86.17(g) did not even know it was being considered for a reimbursement penalty.

At a minimum, hospitals should be given the fair opportunity to be heard on their own behalf and to challenge decisions of the Commissioner when they feel the judgments are in error. The prevailing State attitude is — it will be done our way, without any advance warning, and if you don't like it, sue us. This attitude is wrong — and, in fact, the Department of Health, Education and Welfare has indicated that the State must give hospitals the opportunity for a hearing if there is an alleged unacceptable level of care.

Because Health Department hearings are the final step before seeking relief through the judicial system, state recommendations to dispense with hearings infringe on the rights of the individual. Any pretense of administrative redress becomes a sham and actions of this kind surely exceed legislative intent. Certainly it is counterproductive to reduce the reimbursement rate of a hospital at the time that it is "alleged to be producing an unacceptable level of care." The more reasonable approach would be to work with the hospital to correct the deficiency allowing a reasonable time for the correction to be made.

G. There should be a reduction in regulatory lag.

Regulatory lag is a major problem in the reimbursement process but is also significant in other areas. Historically, rate appeals to the State Health Department have not been reviewed in a timely or uniform fashion. It is common for a hospital to wait for six months to a year to learn of the disposition of an appeal. The Department has no published guidelines on filing or processing appeals. A hospital simply sends a letter requesting an appeal and this is processed on a "hit or miss" basis.

The history of the state's promulgating final reimbursement rates is just as bad. Hospitals did not learn their 1976 Medicaid rates until July of that year. This

eight-month delay precluded rational budgeting for the year causing a significant administrative problem. However, the major problem is that hospitals in New York State provided millions of patient days of service without any knowledge of what the payment for those services might be. The logical assumption was that reimbursement rates would be based on guidelines similar to previous years. This was not the case. When the rates were announced on July 1, about 30% of the hospitals learned reimbursement would be at a rate lower than the previous year's. It was apparently immaterial to the Health Department that these hospitals had provided services in good faith in anticipation of a reasonable level of reimbursement. (The State was even later in announcing Blue Cross reimbursement rates. This report was written in October 1976, 10 months into the year, millions of patient days after rates were expected, and, not one hospital in New York knows what payment it will receive for providing medical services for Blue Cross patients served since January 1976.)

Late notice of reimbursement has been a problem throughout this decade. Finally, a law was passed in 1974 requiring the State to notify hospitals of their rates 60 days before the beginning of the calendar year. That law was amended in the 1976 fiscal crisis. A new law retroactively sanctioned suspending the provision of timely 1976 rates. The present law requires that rates be promulgated 60 days before the rate period. Based on past history, hospitals continue to doubt whether even the new law will be implemented in good faith by the state administration.

Too often the time between the passage of legislation and the promulgation of regulations implementing the law is excessive. Chapter 76 of the Laws of 1976 (Medicaid Cutback Law) is an excellent example. The law included provisions for requiring a second opinion on elective surgery, limiting hospital stays to 20 days and to one-day in pre-operative situations, and constraints on elective surgery to become effective on May 14, 1976. Regulations were not forthcoming from the State Health Department until weeks later with an indication in one memorandum that the Health Department would not initiate compliance surveys until July 1. Sometime later, the State Department of Social Services began separate audits in approximately 20 hospitals. Not only was this duplication of the Health Department surveys, but it placed the hospitals in an untenable position: the Department of Social Services was examining records and auditing procedures for the month of May; the Health Department had not issued official communications about the audits until some months later.

CONCLUSION

In the United States, health departments were originally established to prevent the spread of communicable diseases and undertake epidemiologic activities. Historically, the primary function of health departments, both at the local and state levels, was one of preventive medicine. As we have seen, this has changed drastically in New York State, just within the past ten years.

In this period in New York, the health department has changed from protector of the public health to regulator. Much of this recent regulatory activity has been aimed at saving dollars, not serving patients. The apparent goal of many of the regulations is to minimize the costs to the state without apparent regard for maintaining quality health care or concern for the increased costs to hospitals being mandated by these actions.

The Task Force accepts the necessity for rational regulation. What cannot be accepted and what is being forced upon us is an irrational bureaucracy of staggering proportions and monumental inequities.

APPENDIX A

to the

REPORT OF THE

TASK FORCE ON REGULATION

HOSPITAL ASSOCIATION OF NEW YORK STATE
HIGHLIGHTS OF GAO MEDICAID QUESTIONNAIRE RESPONSES

On May 20, 1976, we sent a questionnaire on Medicaid participation prepared by the GAO to all member hospitals. While the questionnaire had been designed by the GAO and was mailed at their request, we believe that comments on responses to certain questions will be of particular interest to the Task Force on Regulation.

These highlights are taken from the responses to individual questions.

1. **Level of difficulty with laws and regulations** [Question 2(1) and (2)]
   a. Federal — 53% had minor or moderate problems while 29% had substantial or great problems.
   b. State — Only 8% indicated minor or moderate problems while 88% indicated substantial or great problems.

2. **Payment delays** [Question 2(3)]

   43% had minor or moderate problems with 30% indicating moderate (or more severe). Another 52% noted substantial or great problems.

3. **Paperwork** [Question 2(4)]

   Of the 28% which indicated minor or moderate problems with paperwork, 21% indicated a higher level of severity. An additional 69% indicated substantial to great problems with 41% checking the highest level of problem.

4. **Adequacy of the 1976 Interim (Frozen) Rates** [Question 3]

   42% of all questionnaire respondents answered this question. Of those who answered the question, only 10% indicated that the rate was about right while 18% indicated that it was slightly low and 72% indicated that it was far too low.

5. **Anticipated benefit from standard billing methodologies** [Question 6]

   97% of the respondents indicated that they expected a benefit with 26% noting the anticipation of a substantial benefit and 61% indicating the highest level of benefit.

APPENDIX B

to the

REPORT OF THE

TASK FORCE ON REGULATION

PART I — DESCRIPTION OF THE MATRIX INVENTORY METHODOLOGY

In order to fulfill the charge of the Task Force to identify and to classify matters subject to regulation as well as regulatory bodies in a manner which would facilitate the identification of apparent duplications and/or redundancies, a matrix format was selected as a tool to compile and to report the inventory. A separate column was assigned for each different matter subject to regulation. By placing an "x" in each box where a line for a regulatory body intersected a column for a matter subject to regulation, the inventory was compiled. A count of the number of "x's" in a column provided an indication of apparent duplicative regulation of one matter by a number of bodies.

Once the mechanics of the task had been determined, it remained to develop a methodology by which the inventory could be compiled reliably, accurately and completely. Department heads in average hospitals across the state seemed to be the best people to provide specific and detailed information on who regulated what for each of their areas of responsibility within each institution. Working with department heads using a carefully structured and controlled approach to collecting the matrix inventory information seemed likely to yield highly accurate and reliable results.

The Hospital Association of New York State has approximately 300 institutional members of all sizes in every part of the state with a diversity of medical and teaching programs under public or voluntary direction and control. The average member hospital has 200 to 250 beds. Eight hospitals were chosen with the plan that four hospitals would participate in Phase I for the first inventory and the other four hospitals would participate in Phase II to verify the results of Phase I. Phase II would also provide an added degree of assurance that the data was complete and without substantive omissions.

The eight hospitals listed below were selected to insure representation of various geographical locations, public and voluntary sponsorship, and teaching programs. In order to avoid the risk of unnecessarily complicating an already complex task, none was too large. Each hospital's bed complement is indicated in parenthesis next to its name. Genesee and Nassau are classified by the State Health Department as teaching hospitals. With the exception of Binghamton General Hospital, which is sponsored by the City of Binghamton, the others are all voluntary institutions. The hospitals were:

Phase I	Beekman Downtown Hospital (306)	New York
	Genesee Hospital (427)	Rochester
	Geneva General Hospital (172)	Geneva
	Peninsula Hospital Center (270)	Far Rockaway
Phase II	Binghamton General Hospital (380)	Binghamton
	DeGraff Memorial Hospital (235)	North Tonawanda
	Nassau Hospital (501)	Mineola
	New York Infirmary (251)	New York

Each phase began with a meeting in Albany with staff and the hospital executives (usually an assistant administrator or equivalent) who were to conduct the inventory in their institutions. The executives then called special department head meetings in each hospital to distribute the matrix inventory forms and to instruct the department heads on how to complete the task. The department heads were told that the matrix inventory project was an undertaking upon which the hospital placed a high priority and which had potentially great significance for all institutions in the Association.

The Phase I matrix inventory forms had blank column headings and lines. There were two sets of Phase II matrix inventory forms. One set had line and column headings filled-in with the results from Phase I. A set of short definitions of the matters subject to regulation also accompanied the Phase II forms. A list of these definitions is included as Part III of this appendix. The hospital executives served as resource persons for the department heads, collected the completed forms, and submitted them to the Association offices for summarization by staff. Summaries of the matrix inventory findings follow in Part II.

PART II — MATRIX INVENTORY FINDINGS

EXHIBIT

I	Summary of Matrix Inventory Findings
II	Summary Matrix Inventory of Regulations Apparent Duplications and Overlapping Jurisdiction
III	Federal and State Agency Regulations Matrix Inventory Summary

EXHIBIT I

SUMMARY OF MATRIX INVENTORY FINDINGS

Number of Regulatory Bodies:	Number	Cumulative Number	Percent of Total
Federal	40	40	24%
State	96	136	83
City/County	18	154	94
Quasi-Public	3	157	96
Voluntary	7	164	100
	164		

Most Frequently Cited Regulatory Bodies:

Name of Regulatory Body	Number of Matters Regulated
Joint Commission on Accreditation of Hospitals (Voluntary)	85
City/County Health Departments	64
New York State Department of Health Bureau of Hospital Nursing Service	51
New York State Department of Health Bureau of Nutrition	48
Department of Health Education and Welfare — Office of Professional Standards Review	48
New York State Department of Health Bureau of Hospital Certification	45

Total Number of Matters Subject to Regulation: 109

Matters Regulated by the Most Different Bodies:

Matter Subject to Regulation and Major Area of Regulation	Number of Different Bodies
Policies, Procedures and Organization (Administration)	67
Standards of Performance (Administration)	59
Professional Standards (Administration)	53
Accounting and Recording (Financial and Information)	51
Financial and Statistical Reporting (Financial and Information)	51
Certification (Administration)	49
Permits (Administration)	49

SUMMARY MATRIX INVENTORY OF REGULATIONS
APPARENT DUPLICATIONS AND OVERLAPPING JURISDICTIONS

EXHIBIT II

ADMINISTRATIVE SERVICES

	Patient Rights	Civil Rights	Community Relations	Effectiveness of Performance	Permits	Establishment	Certification	Smoking	Disaster Plans	Admitting Procedures	Professional Standards	Standards of Performance	Policies, Procedures and Organization	Governance
NUMBER														
Federal	8	10	11	7	12	4	10	2	2	5	15	17	14	6
State	15	10	15	15	23	6	26	3	4	14	27	32	39	10
Cumulative Subtotal	23	20	26	22	35	10	36	5	6	19	42	49	53	16
City/County	6	2	6	7	9	1	7	3	1	3	7	6	10	—
Cumulative Subtotal	29	22	32	29	44	11	43	8	7	22	49	55	63	16
Quasi-Public	1	—	1	1	2	2	2	1	—	1	1	1	1	—
Voluntary	3	1	1	4	3	1	4	2	2	2	3	3	3	1
TOTAL	33	23	34	34	49	14	49	11	9	25	53	59	67	17
PERCENT OF TOTAL														
Federal	24	43	32	21	24	29	20	18	22	20	28	29	21	35
State	45	43	44	44	47	43	53	27	44	56	51	54	58	59
Cumulative Subtotal	70%	87%	76%	65%	71%	71%	73%	45%	67%	76%	79%	83%	79%	94%
City/County	18	9	18	21	18	7	14	27	11	12	13	10	15	—
Cumulative Subtotal	88%	96%	94%	85%	90%	79%	88%	73%	78%	88%	92%	93%	94%	94%
Quasi-Public	3	—	3	3	4	14	4	9	—	4	2	2	1	—
Voluntary	9	4	3	12	6	7	8	18	22	8	6	5	4	6

EXHIBIT II

SUMMARY MATRIX INVENTORY OF REGULATIONS
APPARENT DUPLICATIONS AND OVERLAPPING JURISDICTIONS

ANCILLARY SERVICES

	Radiation Protection	Radioactive Substances	Sale of Drugs	Packaging	Labeling	Narcotics Control	Drugs and Medications Control	Alcohol Control
NUMBER								
Federal	3	3	3	4	5	3	5	2
State	3	5	6	8	9	8	11	2
Cumulative Subtotal	6	8	9	12	14	11	16	4
City/County	—	—	—	1	1	—	1	—
Cumulative Subtotal	6	8	9	13	15	11	17	4
Quasi-Public	—	—	—	—	—	1	1	—
Voluntary	1	1	—	2	2	2	2	2
TOTAL	7	9	9	15	17	14	20	6
PERCENT OF TOTAL								
Federal	43	33	33	27	29	21	25	33
State	43	56	67	53	53	57	55	33
Cumulative Subtotal	86%	89%	100%	80%	82%	79%	80%	67%
City/County	—	—	—	7	6	—	5	—
Cumulative Subtotal	86%	89%	100%	87%	88%	79%	85%	67%
Quasi-Public	—	—	—	—	—	7	5	—
Voluntary	14	11	—	13	12	14	10	33

EXHIBIT II

SUMMARY MATRIX INVENTORY OF REGULATIONS
APPARENT DUPLICATIONS AND OVERLAPPING JURISDICTIONS

EDUCATIONAL SERVICES

	Supervision of Residents	Student Health Services	Student Financial Aid	Housing	Faculty	Curriculum
NUMBER						
Federal	1	—	2	1	2	2
State	—	2	4	1	5	4
Cumulative Subtotal	1	2	6	2	7	6
City/County	1	—	—	2	—	1
Cumulative Subtotal	2	2	6	4	7	7
Quasi-Public	—	—	—	—	—	—
Voluntary	3	—	—	—	3	2
TOTAL	5	2	6	4	10	9
PERCENT OF TOTAL						
Federal	20	—	33	25	20	22
State	—	100	67	25	50	44
Cumulative Subtotal	20%	100%	100%	50%	70%	67%
City/County	20	—	—	50	—	11
Cumulative Subtotal	40%	100%	100%	100%	70%	78%
Quasi-Public	—	—	—	—	—	—
Voluntary	60	—	—	—	30	22

SUMMARY MATRIX INVENTORY OF REGULATIONS
APPARENT DUPLICATIONS AND OVERLAPPING JURISDICTIONS

EXHIBIT II

FACILITY SERVICES

	Public Safety	Water	Energy Conservation	Light, Heat, and Power	Pest Control	Sterility	Waste Disposal	Sanitation	Environment	Operation	Emergency Power	Fire Control	Equipment	Material Storage	Parking	Construction
NUMBER																
Federal	3	1	—	1	3	4	4	3	4	6	—	—	4	5	1	8
State	13	9	7	8	8	10	18	14	15	22	8	12	14	16	6	16
Cumulative Subtotal	16	10	7	9	11	14	22	17	19	28	8	12	18	21	7	24
City/County	5	4	2	2	2	2	4	4	6	5	1	3	4	2	4	5
Cumulative Subtotal	21	14	9	11	13	16	26	21	25	33	9	15	22	23	11	29
Quasi-Public	—	—	—	—	—	1	—	1	1	3	—	—	—	—	—	—
Voluntary	3	1	—	2	1	1	1	2	2	3	1	4	4	4	—	—
TOTAL	24	15	9	13	14	18	27	24	28	39	10	19	26	27	11	29
PERCENT OF TOTAL																
Federal	13	7	—	8	21	22	15	13	14	15	—	—	15	19	9	28
State	54	60	78	62	57	56	67	58	54	56	80	63	54	59	55	55
Cumulative Subtotal	67%	67%	78%	69%	79%	78%	81%	71%	68%	72%	80%	63%	69%	78%	64%	83%
City/County	21	27	22	15	14	11	15	17	21	13	10	16	15	7	36	17
Cumulative Subtotal	88%	93%	100%	85%	93%	89%	96%	88%	89%	85%	90%	79%	85%	85%	100%	100%
Quasi-Public	—	—	—	—	—	6	—	4	4	8	—	—	—	—	—	—
Voluntary	13	7	—	15	7	6	4	8	7	8	10	21	15	15	—	—

EXHIBIT II

SUMMARY MATRIX INVENTORY OF REGULATIONS
APPARENT DUPLICATIONS AND OVERLAPPING JURISDICTIONS

FINANCIAL AND INFORMATION SERVICES

	Beneficiary Benefits	Reimbursement	Free Care	Taxes	Grants	Contributions	Cost Control	Budgeting	Financial and Statistical Reporting	Accounting and Recording
NUMBER										
Federal	10	10	3	2	3	3	2	4	10	13
State	8	18	4	5	7	7	8	10	30	28
Cumulative Subtotal	18	28	7	7	10	10	10	14	40	41
City/County	2	3	—	1	2	1	1	1	4	3
Cumulative Subtotal	20	31	7	8	12	11	11	15	44	44
Quasi-Public	2	2	1	—	1	—	3	2	3	3
Voluntary	2	2	1	1	1	1	1	2	4	4
TOTAL	24	35	9	9	14	12	15	19	51	51
PERCENT OF TOTAL										
Federal	42	29	33	22	21	25	13	21	20	25
State	33	51	44	56	50	58	53	53	59	55
Cumulative Subtotal	75%	80%	78%	78%	71%	83%	67%	74%	78%	80%
City/County	8	9	—	11	14	8	7	5	8	6
Cumulative Subtotal	83%	89%	78%	89%	86%	92%	73%	79%	86%	86%
Quasi-Public	8	6	11	—	7	—	20	11	6	6
Voluntary	8	6	11	11	7	8	7	11	8	8

EXHIBIT II

SUMMARY MATRIX INVENTORY OF REGULATIONS
APPARENT DUPLICATIONS AND OVERLAPPING JURISDICTIONS

MEDICAL SERIVCES — DELIVERY

	Patient Safety	Medical Records	Services Delivered	Length of Stay	Quality of Care	Utilization Review Plan	Communicable Disease Control	Infection Control	Drug Profiles	Accessibility	New Services	Levels of Care	Breadth of Service
NUMBER													
Federal	7	13	8	9	7	10	3	3	3	3	3	10	6
State	16	22	20	12	17	16	7	8	2	4	11	17	17
Cumulative Subtotal	23	35	28	21	24	26	10	11	5	7	14	27	23
City/County	3	4	5	3	4	3	1	2	1	2	2	4	3
Cumulative Subtotal	26	39	33	24	28	29	11	13	6	9	16	31	26
Quasi-Public	1	2	3	2	2	2	—	—	—	—	2	2	1
Voluntary	4	3	3	3	3	3	2	2	2	3	2	3	3
TOTAL	31	44	39	29	33	34	13	15	8	12	20	36	30
PERCENT OF TOTAL													
Federal	23	30	21	31	21	29	23	20	38	25	15	28	20
State	52	50	51	41	52	47	54	53	25	33	55	47	57
Cumulative Subtotal	74%	80%	72%	72%	73%	76%	77%	73%	63%	58%	70%	75%	77%
City/County	10	9	13	10	12	9	8	13	13	17	10	11	10
Cumulative Subtotal	84%	89%	85%	83%	85%	85%	85%	87%	75%	75%	80%	86%	87%
Quasi-Public	3	5	8	7	6	6	—	—	—	—	10	6	3
Voluntary	13	7	8	10	9	9	15	13	25	25	10	8	10

EXHIBIT II

SUMMARY MATRIX INVENTORY OF REGULATIONS
APPARENT DUPLICATIONS AND OVERLAPPING JURISDICTIONS

MEDICAL SERVICES — SPECIAL PROGRAMS

	Drug Abuse	Child Abuse	Adoption	Termination of Pregnancy	Pregnancy Information	Birth Certificates	Death Certificates	Crime Victims	Ambulance
NUMBER									
Federal	3	3	—	—	—	—	—	—	—
State	2	2	2	2	4	3	1	—	3
Cumulative Subtotal	5	5	2	2	4	3	1	—	3
City/County	4	4	2	2	2	2	1	2	—
Cumulative Subtotal	9	9	4	4	6	5	2	2	3
Quasi-Public	—	—	—	—	—	—	—	—	1
Voluntary	1	1	—	1	1	1	1	—	—
TOTAL	10	10	4	5	7	6	3	2	4
PERCENT OF TOTAL									
Federal	30	30	—	—	—	—	—	—	—
State	20	20	50	40	57	50	33	—	75
Cumulative Subtotal	50%	50%	50%	40%	57%	50%	33%	—	75%
City/County	40	40	50	40	29	33	33	100	—
Cumulative Subtotal	90%	90%	100%	80%	86%	83%	67%	100%	75%
Quasi-Public	—	—	—	—	—	—	—	—	25
Voluntary	10	10	—	20	14	17	33	—	—

EXHIBIT II

SUMMARY MATRIX INVENTORY OF REGULATIONS
APPARENT DUPLICATIONS AND OVERLAPPING JURISDICTIONS

MEDICAL SERVICES ORGANIZATION

	Research	Health Standards	Staffing	Physical & Mental Status of Medical Staff	Attending Staff Privileges	Board Certification	Registration	Licensure	Accreditation
NUMBER									
Federal	—	5	3	2	—	—	3	4	4
State	5	14	10	5	1	5	15	23	11
Cumulative Subtotal	5	19	13	7	1	5	18	27	15
City/County	2	6	2	2	—	—	2	3	2
Cumulative Subtotal	7	25	15	9	1	5	20	30	17
Quasi-Public	1	1	1	—	—	—	1	3	2
Voluntary	3	2	2	1	1	1	3	4	5
TOTAL	11	28	18	10	2	6	24	37	24
PERCENT OF TOTAL									
Federal	—	18	17	20	—	—	13	11	17
State	45	50	56	50	50	83	63	62	46
Cumulative Subtotal	45%	68%	72%	70%	50%	83%	75%	73%	63%
City/County	18	21	11	20	—	—	8	8	8
Cumulative Subtotal	64%	89%	83%	90%	50%	83%	83%	81%	71%
Quasi-Public	9	4	6	—	—	—	4	8	8
Voluntary	27	7	11	10	50	17	13	11	21

EXHIBIT II

SUMMARY MATRIX INVENTORY OF REGULATIONS
APPARENT DUPLICATIONS AND OVERLAPPING JURISDICTIONS

PERSONNEL SERVICES

NUMBER	Volunteers	Supervision	Training	Fair Labor Practices	Dress Code and Uniforms	Discrimination	Hiring	Safety	Employee Health Services	Records	Disability Insurance	Workmen's Compensation	Unemployment Insurance	Payroll Taxes	Fringes	Wages
Federal	4	11	13	5	2	6	7	3	2	10	2	3	3	3	7	9
State	2	17	23	6	6	9	13	8	9	20	6	7	8	3	8	11
Cumulative Subtotal	6	28	36	11	8	15	20	11	11	30	8	10	11	6	15	20
City/County	1	2	5	—	1	1	1	4	1	1	—	—	—	1	1	2
Cumulative Subtotal	7	30	41	11	9	16	21	15	12	31	8	10	11	7	16	22
Quasi-Public	—	1	1	—	—	—	—	—	—	2	—	—	—	1	1	1
Voluntary	2	3	5	—	1	—	1	4	2	4	1	1	1	—	3	2
TOTAL	9	34	47	11	10	16	22	19	14	37	9	11	12	8	20	25
PERCENT OF TOTAL																
Federal	44	32	28	50	20	38	32	16	14	27	22	27	25	38	35	36
State	22	50	49	50	60	56	59	42	64	54	67	64	67	38	40	40
Cumulative Subtotal	67%	82%	77%	100%	80%	94%	90%	58%	79%	81%	89%	91%	92%	75%	75%	80%
City/County	11	6	11	—	10	6	5	21	7	3	—	—	—	13	5	8
Cumulative Subtotal	78%	88%	87%	100%	90%	100%	95%	79%	86%	84%	89%	91%	92%	88%	80%	88%
Quasi-Public	—	3	2	—	—	—	—	—	—	5	—	—	—	13	5	4
Voluntary	22	9	11	—	10	—	5	21	14	11	11	9	8	—	15	8

EXHIBIT II

SUMMARY MATRIX INVENTORY OF REGULATIONS
APPARENT DUPLICATIONS AND OVERLAPPING JURISDICTIONS

SUPPORT SERVICES

	Package Control	Security	Transportation	Communications	Laundry	Food	Material Usage	Purchasing
NUMBER								
Federal	5	2	4	8	1	2	7	6
State	7	4	7	5	4	5	13	12
Cumulative Subtotal	12	6	11	13	5	7	20	18
City/County	3	4	4	1	1	2	3	4
Cumulative Subtotal	15	10	15	14	6	9	23	22
Quasi-Public	1	—	—	3	1	1	1	1
Voluntary	2	3	3	4	2	3	3	2
TOTAL	18	13	18	21	9	13	27	25
PERCENT OF TOTAL								
Federal	27	15	22	38	11	15	26	24
State	39	31	39	24	44	38	48	48
Cumulative Subtotal	67%	46%	61%	62%	56%	54%	74%	72%
City/County	17	31	22	5	11	15	11	16
Cumulative Subtotal	83%	77%	83%	67%	67%	69%	85%	88%
Quasi-Public	6	—	—	14	11	8	4	4
Voluntary	11	23	17	19	22	23	11	8

EXHIBIT III

FEDERAL AND STATE AGENCY REGULATIONS MATRIX INVENTORY SUMMARY

ADMINISTRATIVE SERVICES

	Patient Rights	Civil Rights	Community Relations	Effectiveness of Performance	Permits	Establishment	Certification	Smoking	Disaster Plans	Admitting Procedures	Professional Standards	Standards of Performance	Policies, Procedures and Organization	Governance
FEDERAL														
Department of Health, Education and Welfare	7	7	7	5	5	3	6	2	1	5	12	13	13	4
All Others	1	3	4	2	7	1	4	—	1	—	3	4	1	2
TOTAL	8	10	11	7	12	4	10	2	2	5	15	17	14	6
STATE DEPARTMENTS														
Health	7	2	2	12	12	4	17	2	3	10	21	23	25	3
Education	—	—	1	1	1	—	1	—	—	—	1	1	—	1
Environmental Conservation	—	—	—	—	1	1	1	—	—	—	—	—	1	—
Labor	—	5	2	—	1	—	—	—	—	1	—	1	4	—
Mental Hygiene	2	—	—	1	—	—	1	—	—	1	1	1	3	—
Social Services	3	—	3	1	—	—	1	—	—	1	1	1	3	—
State	—	—	2	—	2	—	1	1	1	—	—	—	—	1
Taxation and Finance	—	—	2	—	—	1	2	—	—	—	—	1	—	1
All Others	3	3	3	—	6	—	2	—	—	1	3	4	3	4
TOTAL	15	10	15	15	23	6	26	3	4	14	27	32	39	10

EXHIBIT III

FEDERAL AND STATE AGENCY
REGULATIONS MATRIX INVENTORY SUMMARY

ANCILLARY SERVICES

	Radiation Protection	Radioactive Substances	Sales of Drugs	Packaging	Labeling	Narcotics Control	Drugs and Medications Control	Alcohol Control
FEDERAL								
Department of Health, Education and Welfare	1	1	2	1	2	2	3	1
All Others	2	2	1	3	3	1	2	1
TOTAL	3	3	3	4	5	3	5	2
STATE DEPARTMENTS								
Health	2	4	4	6	7	6	8	1
Education	—	—	—	—	—	—	—	—
Environmental Conservation	—	1	—	—	—	—	—	—
Labor	—	—	—	—	—	—	—	—
Mental Hygiene	—	—	—	—	—	—	1	—
Social Services	—	—	—	—	—	—	—	—
State	—	—	—	—	—	—	—	—
Taxation and Finance	—	—	—	—	—	—	—	—
All Others	1	—	2	2	2	2	2	1
TOTAL	3	5	6	8	9	8	11	2

EXHIBIT III

FEDERAL AND STATE AGENCY

REGULATIONS MATRIX INVENTORY SUMMARY

EDUCATIONAL SERVICES

	Supervision of Residents	Student Health Services	Student Financial Aid	Housing	Faculty	Curriculum
FEDERAL						
Department of Health, Education and Welfare	1	—	1	1	2	1
All Others	—	—	1	—	—	1
TOTAL	1		2	1	2	2
STATE DEPARTMENTS						
Health	—	1	—	—	4	3
Education	—	—	—	—	1	1
Environmental Conservation	—	—	—	—	—	—
Labor	—	—	—	—	—	—
Mental Hygiene	—	—	—	—	—	—
Social Services	—	—	—	—	—	—
State	—	—	—	—	—	—
Taxation and Finance	—	—	1	—	—	—
All Others	—	1	3	1	—	—
TOTAL		2	4	1	5	4

EXHIBIT III

FEDERAL AND STATE AGENCY REGULATIONS MATRIX INVENTORY SUMMARY

FACILITY SERVICES

	Public Safety	Water	Energy Conservation	Light, Heat, and Power	Pest Control	Sterility	Waste Disposal	Sanitation	Environment	Operation	Emergency Power	Fire Control	Equipment	Material Storage	Parking	Construction
FEDERAL																
Department of Health, Education and Welfare	2	1	—	1	3	4	3	3	3	6	—	—	2	2	1	3
All Others	1	—	—	—	—	—	1	—	1	—	—	—	2	3	—	5
TOTAL	3	1		1	3	4	4	3	4	6			4	5	1	8
STATE DEPARTMENTS																
Health	7	7	4	6	8	10	14	10	8	13	6	8	10	14	4	6
Education	—	—	—	—	—	—	—	—	—	1	—	—	—	—	—	—
Environmental Conservation	1	1	1	—	—	—	3	3	4	1	—	—	1	—	—	1
Labor	1	—	—	—	—	—	—	—	—	1	—	1	1	1	—	1
Mental Hygiene	—	—	—	—	—	—	—	—	1	1	1	1	—	—	1	1
Social Services	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
State	—	—	—	—	—	—	—	—	1	1	—	2	1	—	1	2
Taxation and Finance	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2
All Others	4	1	2	2	—	—	1	1	1	4	1	—	1	1	—	3
TOTAL	13	9	7	8	8	10	18	14	15	22	8	12	14	16	6	16

FEDERAL AND STATE AGENCY REGULATIONS MATRIX INVENTORY SUMMARY

FINANCIAL AND INFORMATION SERVICES

	Beneficiary Benefits	Reimbursement	Free Care	Taxes	Grants	Contributions	Cost Control	Budgeting	Financial and Statistical Reporting	Accounting and Recording
FEDERAL										
Department of Health, Education and Welfare	7	8	3	1	2	1	2	3	7	10
All Others	3	2	—	1	1	2	—	1	3	3
TOTAL	10	10	3	2	3	3	2	4	10	13
STATE DEPARTMENT										
Health	5	7	2	—	1	1	7	8	19	16
Education	—	1	—	—	1	—	—	—	1	—
Environmental Conservation	—	—	—	—	—	—	—	—	—	1
Labor	—	—	—	—	—	—	—	—	1	1
Mental Hygiene	—	1	2	—	—	—	—	—	—	—
Social Services	1	1	—	—	—	—	—	—	—	1
State	—	—	—	—	—	—	—	—	—	—
Taxation and Finance	—	—	—	3	3	3	—	—	2	2
All Others	2	8	—	2	2	3	1	2	7	7
TOTAL	8	18	4	5	7	7	8	10	30	28

EXHIBIT III

FEDERAL AND STATE AGENCY REGULATIONS MATRIX INVENTORY SUMMARY

MEDICAL SERVICES — DELIVERY

	Patient Safety	Medical Records	Services Delivered	Length of Stay	Quality of Care	Utilization Review Plan	Communicable Disease Control	Infection Control	Drug Profiles	Accessibility	New Services	Levels of Care	Breadth of Service
FEDERAL													
Department of Health, Education and Welfare	5	11	8	9	7	10	3	3	3	3	2	9	4
All Others	2	2	—	—	—	—	—	—	—	—	1	1	2
TOTAL	7	13	8	9	7	10	3	3	3	3	3	10	6
STATE DEPARTMENT													
Health	13	11	10	7	12	10	6	7	2	3	10	10	10
Education	—	1	2	1	1	1	—	—	—	—	—	2	2
Environmental Conservation	1	1	1	—	—	—	—	—	—	—	—	—	—
Labor	1	—	—	—	—	—	—	—	—	—	—	—	—
Mental Hygiene	—	3	3	1	1	1	1	1	—	—	1	1	2
Social Services	—	—	—	1	1	1	—	—	—	—	—	3	—
State	—	—	—	—	—	—	—	—	—	—	—	—	—
Taxation and Finance	—	—	—	—	—	—	—	—	—	—	—	—	—
All Others	1	6	4	2	2	3	—	—	—	1	—	1	3
TOTAL	16	22	20	12	17	16	7	8	2	4	11	17	17

EXHIBIT III

FEDERAL AND STATE AGENCY REGULATIONS MATRIX INVENTORY SUMMARY

MEDICAL SERVICES — SPECIAL PROGRAMS

	Drug Abuse	Child Abuse	Adoption	Termination of Pregnancy	Pregnancy Information	Birth Certificates	Death Certificates	Crime Victims	Ambulance
FEDERAL									
Department of Health, Education and Welfare	2	3	—	—	—	—	—	—	—
All Others	1	—	—	—	—	—	—	—	—
TOTAL	3	3							
STATE DEPARTMENTS									
Health	1	—	—	2	4	3	1	—	2
Education	—	—	—	—	—	—	—	—	—
Environmental Conservation	—	—	—	—	—	—	—	—	—
Labor	—	—	—	—	—	—	—	—	—
Mental Hygiene	—	—	—	—	—	—	—	—	—
Social Services	—	1	1	—	—	—	—	—	—
State	—	—	—	—	—	—	—	—	—
Taxation and Finance	—	—	—	—	—	—	—	—	—
All Others	1	1	1	—	—	—	—	—	1
TOTAL	2	2	2	2	4	3	1		3

EXHIBIT I

FEDERAL AND STATE AGENCY REGULATIONS MATRIX INVENTORY SUMMARY

MEDICAL SERVICES — ORGANIZATION

	Research	Health Standards	Staffing	Physical & Mental Status of Medical Staff	Attending Staff Privileges	Board Certification	Registration	Licensure	Accreditation
FEDERAL									
Department of Health, Education and Welfare	—	5	3	2	—	—	2	3	3
All Others	—	—	—	—	—	—	1	1	1
TOTAL		5	3	2			3	4	4
STATE DEPARTMENTS									
Health	5	11	8	5	1	4	11	17	9
Education	—	1	1	—	—	1	1	1	1
Environemental Conservation	—	2	—	—	—	—	—	—	—
Labor	—	—	—	—	—	—	—	—	—
Mental Hygiene	—	—	—	—	—	—	1	—	—
Social Services	—	—	—	—	—	—	—	—	—
State	—	—	—	—	—	—	—	1	1
Taxation and Finance	—	—	—	—	—	—	—	—	—
All Others	—	—	1	—	—	—	2	4	—
TOTAL	5	14	10	5	1	5	15	23	11

EXHIBIT III

FEDERAL AND STATE AGENCY REGULATIONS MATRIX INVENTORY SUMMARY

PERSONNEL SERVICES

	Volunteers	Supervision	Training	Fair Labor Practices	Dress Code and Uniforms	Discrimination	Hiring	Safety	Employee Health Services	Records	Disability Insurance	Workmen's Compensation	Unemployment Insurance	Payroll Taxes	Fringes	Wages
FEDERAL																
Department of Health Education and Welfare	1	6	8	2	1	3	3	—	2	5	1	1	1	1	3	5
All Others	3	5	5	2	1	3	4	3	—	5	1	2	2	2	4	4
TOTAL	4	11	13	5	2	6	7	3	2	10	2	3	3	3	7	9
STATE DEPARTMENTS																
Health	—	7	11	—	2	1	5	5	6	8	—	—	—	—	—	—
Education	—	1	1	—	1	—	1	—	—	—	—	—	—	—	—	—
Environmental Conservation	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Labor	1	4	4	3	1	6	4	1	2	5	3	3	5	1	4	5
Mental Hygiene	—	1	1	—	—	—	—	—	—	—	—	—	—	—	—	—
Social Services	—	1	1	—	—	—	1	—	—	1	—	—	—	—	—	—
State	—	—	—	—	1	—	—	1	—	1	—	—	—	—	—	—
Taxation and Finance	—	—	—	—	—	—	—	—	—	1	—	—	1	1	1	2
All Others	1	3	5	3	1	2	2	1	1	4	3	4	2	1	3	4
TOTAL	2	17	23	6	6	9	13	8	9	20	6	7	8	3	8	11

EXHIBIT III

FEDERAL AND STATE AGENCY REGULATIONS MATRIX INVENTORY SUMMARY

SUPPORT SERVICES

	Package Control	Security	Transportation	Communications	Laundry	Food	Material Usage	Purchasing
FEDERAL								
Department of Health, Education and Welfare	1	—	—	5	1	1	2	1
All Others	4	2	4	3	—	1	5	5
TOTAL	5	2	4	8	1	2	7	6
STATE DEPARTMENT								
Health	6	2	3	4	4	4	11	8
Education	—	—	—	—	—	—	1	—
Environmental Conservation	—	—	—	—	—	—	—	—
Labor	—	—	—	1	—	—	—	1
Mental Hygiene	—	—	—	—	—	—	—	—
Social Services	—	—	—	—	—	—	—	—
State	—	1	1	—	—	—	—	—
Taxation and Finance	—	—	—	—	—	—	—	—
All Others	1	1	3	—	—	1	1	3
TOTAL	7	4	7	5	4	5	13	12

PART III — DEFINITIONS OF MATTERS SUBJECT TO REGULATION

ADMINISTRATIVE SERVICES

1. Governance — Governing board, board of trustees, or other bodies charged with similar responsibilities but perhaps with a different name.
2. Policies, Procedures and Organization — Formal written documentation of both the policies and procedures as well as the organizational structure charged with their implementation in the daily administration of the institution.
3. Standards of Performance — Formal written documentation by which the performance of the administration will be measured in carrying out the institution's policies and procedures.
4. Professional Standards — Formal written documentation of standards of performance which relate to the discharge of the responsibilities of specially trained employees recognized as professionals by appropriate governmental, educational, or other agencies.
5. Admitting Procedures — Formal written documentation which establishes the criteria (including but not limited to medical and financial) under which the admitting function of the institution is carried out.
6. Disaster Plans — Formal written documentation which specifies how the institution will respond to disasters (such as fires or floods) which may directly affect the facility as well as any number of disasters which may occur within the community served by the institution so that the institution is prepared for immediate and appropriate responses to specific emergencies.
7. Smoking — Formal written documentation which relates to the practice of smoking by anyone anywhere in the facility.
8. Certification — Obtaining appropriate certificates, approvals, endorsements, licenses, and similar documentation relating to the operation of the entire institution.
9. Establishment — Obtaining appropriate approvals to establish an institution or a major area of activity within the institution. This category would not include the approval of a new service which would be reported in the category entitled Medical Services — Delivery.
10. Permits — Generally relating to the obtaining of a permit or license to perform some activity which is generally limited in duration or scope and which generally relates to the managerial areas of responsibility within the institution.
11. Effectiveness of Performance — A formal procedure to measure the results of activities against previously established standards and policies.
12. Community Relations — Areas of activity by which the institution relates to its community. This includes: health communications, public relations, fund raising, highway signs, media relations, etc.
13. Civil Rights — Relates to assurances that the institution does not disregard or violate individual civil rights in all areas of its activity except those which relate to patients (see Patient Rights) or employees (see Discrimination under Personnel Services).
14. Patient Rights — Relates to all areas which pertain to the individual civil rights of patients and other requirements or documentation such as the Patient's Bill of Rights.

ANCILLARY SERVICES

1. Alcohol Control — Relates to alcohol as a controlled substance (generally in the pharmacy).
2. Drugs and Medications Control — Relates to pharmaceuticals and chemicals generally regarded as controlled substances and generally under the direction of the pharmacy. Excludes alcohol and/or narcotics.
3. Narcotics Control — Relates to narcotics as a controlled substance (generally in the pharmacy).
4. Labeling — Relates to the identification affixed to materials used within the institution. Most frequently relates to controlled substances.
5. Packaging — Relates to the encasement, labeling, containerization, etc. of materials used in the facility. Generally relates to controlled substances.

6. Sale of Drugs — Relates to the dispensing of medications and pharmaceuticals "over the counter" to individuals who are not inpatients at the time of the sale.
7. Radioactive Substances — Relates to all materials generally considered to be radioactive.
8. Radiation Protection — Relates to the protection of persons, materials and/or supplies from the effects of radioactive substances or equipment which may emit radiation.

EDUCATIONAL SERVICES

1. Curriculum — Pertaining to the syllabus and other specific content of formal educational programs.
2. Faculty — Pertains to instructors and other individuals responsible for the conduct of formal educational programs.
3. Housing — Relating to dormitory facilities for students enrolled in formal educational programs of the institution which might include: student nurses, interns, residents, etc.
4. Student Financial Aid — Any financial assistance offered to students to defray the cost of their education which would otherwise be the student's responsibility.
5. Student Health Services — A discrete facility which ministers to the health care needs of students enrolled in formal educational programs of the institution.
6. Supervision of Residents — Attending physicians and others directly related to the supervision of students in post-graduate medical educational programs run by the institution.

FACILITY SERVICES

1. Construction — Includes approval of construction, construction materials, specifications, and anything else which relates to the real property comprising the structure of the facility.
2. Parking — Anything to do with parking structures, lots, or other accommodations.
3. Material Storage — Construction features, specifications, materials, etc., relating to the storage of materials and supplies used by the facility including controlled substances, radioactive substances, flammable substances, perishables, etc.
4. Equipment — Physical characteristics of equipment, safety features, specifications, purchase authorizations, etc., would fall in this category. Fixed equipment which becomes part of the structure of the facility would be reported under Construction. Only equipment which is appropriately categorized as personal property and not real property is applicable to this category.
5. Fire Control — Construction features, special devices, physical systems, etc., whose purpose is to prevent, quench, or contain fires, smoke, explosions, etc.
6. Emergency Power — Special auxiliary generating equipment and systems which become operative in the event of the inability of the local utility to supply power normally purchased.
7. Operation — Having to do with the use and functioning of the physical plant facility.
8. Environment — Relates to impacts of the operation of the facility upon the community surrounding the institution.
9. Sanitation — Pertaining to the maintenance of the facility in a clean and sanitary fashion. Many institutions may consider this as a housekeeping function.
10. Waste Disposal — Systems, equipment, devices, etc., used to dispose of all waste materials resulting from the daily activities of the institution. This would include incinerators and compactors as well as trash haulage.
11. Sterility — Relates to the maintenance of sterile conditions within the institution.
12. Pest Control — All activities designed to eliminate vermin, rodents, insects, and other pests.
13. Light, Heat, and Power — Utilities and all materials purchased to operate the plant including electricity, steam, fuel oils and gases, coal, etc.
14. Energy Conservation — Relates to the conservation of materials, supplies and services used to provide light, heat and power.
15. Water — Pertaining to the supplying of water to the facility for human consumption, for toilet facilities, for cleaning uses, etc.

16. Public Safety — All matters which relate to the prevention of injuries to visitors, guests, independent contractors, salesmen, consultants, and all other individuals except those who are either patients or employees.

FINANCIAL AND INFORMATION SERVICES

1. Accounting and Recording — Maintenance of all records in all departments including but not limited to the books of account, departmental registers and logs, EDP media, etc.
2. Financial and Statistical Reporting — Pertains to reports derived from the financial and statistical records maintained by any department or subdivision of the institution as described in Accounting and Recording above.
3. Budgeting — Formal written documentation of the institution relating to plans for operating results, capital requirements, cash flow, or other special activities.
4. Cost Control — Directed at the containment of costs, the elimination of costs, the reduction in the rate of increase of costs, and all other efforts at improving an institution's cost effectiveness.
5. Contributions — Anything relating to the receipt of philanthropy by the institution and the reporting of such activities.
6. Grants — All sources of funding from public, private, or voluntary sources to support special activities which may not generate patient service revenues. Such grants might be for the purpose of: research, offsetting losses, supporting activities not otherwise funded which might include the initiation of new services with seed money, etc.
7. Taxes — Reports and payments to tax collecting bodies at all governmental levels. Includes income taxes on unrelated business income, sales tax, information reports on tax exempt activities, and real property tax. Does not include taxes withheld from employees paid in connection with their employment.
8. Free Care — Relates to services rendered without compensation to patients unable to pay, such as those which might be categorized as free care under rules such as those of the Hill-Burton Program.
9. Reimbursement — Compensation for services rendered to patients.
10. Beneficiary Benefits — Coverage of services rendered to patients who are eligible as beneficiaries under public or private insurance programs.

MEDICAL SERVICES — DELIVERY

1. Breadth of Service — Formal policies, procedures, authorizations, etc., relating to the extent of different services to be offered or, conversely, limitations thereof.
2. Levels of Care — Formal methodologies to identify the changing needs of patients for more or less intensive levels of care and for the provision of services at such appropriate levels either within or outside of the institution.
3. New Services — The approval, certification, initiation, or implementation of patient services not previously rendered by the institution.
4. Accessibility — The availability of the full range of patient services provided by the institution to all members of the community.
5. Drug Profiles — Formal Records relating to patient medications, sensitivities, interactions, etc.
6. Infection Control — Formal systems to insure against the spread of infection within the institution.
7. Communicable Disease Control — Formal systems to insure against the spread of communicable diseases within the institution.
8. Utilization Review Plan — The formal plan to insure appropriate medical review of services rendered to patients.
9. Quality of Care — The formal system of medical review of patient services to insure adherence to predetermined standards of quality.
10. Length of Stay — The formal system of medical review of the number of days a patient is hospitalized to insure that it is consistent with both quality and efficiency considerations.

11. Services Rendered — The medical review of services rendered to individual patients which, presumably, would be related to the diagnosis as well as to their individual physical condition.
12. Medical Records — The maintenance of appropriate records relating to services rendered to each patient as well as systems for the review of such medical records and for the reporting and analysis of any information from them.
13. Patient Safety — Anything relating to the prevention of injury to a patient.

MEDICAL SERVICES — SPECIAL PROGRAMS

1. Ambulance — An organized ambulance service provided by the institution to transport patients to or from the facility when they are unable to use other means of transportation.
2. Crime Victims — Special programs relating to the treatment of injuries inflicted upon victims of criminal acts.
3. Death Certificates — The system of recording and reporting deaths.
4. Birth Confirmation — The system of recording and reporting births.
5. Pregnancy Information — Relating to programs whose purpose is to gather data on pregnancy.
6. Termination of Pregnancy — Relating to programs whose purpose is to gather data on termination of pregnancy.
7. Adoption — Programs relating to the adoption of children.
8. Child Abuse — Programs related to child abuse.
9. Drug Abuse — Programs related to the abuse of narcotics and addiction.

MEDICAL SERVICES — ORGANIZATION

1. Accreditation — Relating to the formal act of accreditation by appropriate bodies.
2. Licensure — Relating to the licensing rules which apply to all those who render services to patients.
3. Registration — Registering individuals, services, or entire institutions with those bodies requiring such registration in order to permit rendering of medical services.
4. Board Certification — Relating to the certification of physicians to practice as specialists.
5. Attending Staff Privileges — The formal rules and procedures for the granting of attending privileges to individual physicians.
6. Physical and Mental Status of Medical Staff — Relating to evaluations whose purpose is to insure that physicians on the medical staff are physically and mentally fit to perform their duties.
7. Staffing — Relating to the number and type of skills required in various patient service areas.
8. Health Standards — Formal written medical standards of the institution which define the individual qualifications of those rendering patient services as well as medical standards to be used in evaluating the quality and extent of medical services rendered.
9. Research — Anything relating to research activities not specifically and directly related to patient care.

PERSONNEL SERVICES

1. Wages — All compensation of employees. Includes: hourly rates, weekly salaries, annual salaries, etc. Also includes such special arrangements as stand-by pay. Does not include payments to independent contractors who provide personal services but who are not bona fide employees.
2. Fringes — Payments to and/or on behalf of employees in addition to wages. Includes: health insurance, life insurance, pensions, perquisites, etc. May include time paid but not worked, such as: sick pay, vacations, personal leave, etc. Does not include payments for programs required by law such as Social Security, unemployment insurance, workmen's compensation insurance, disability insurance, etc. Thus, this category relates only to voluntary fringe benefits.

3. Payroll Taxes — Includes all amounts withheld from employee's wages, such as: income taxes, FICA, etc.
4. Unemployment Insurance — Pertains to both federal and state programs whether paid through taxes or whether self-insured.
5. Workmen's Compensation — Pertains to the New York State workmen's compensation statutes only as they relate to an institution's employees. Does not include medical services rendered for work-related injuries to employees of other employers or reimbursement for services being made under the Workmen's Compensation Law by either the other employer or its insurer.
6. Disability Insurance — Includes the New York State statutory requirement regardless of whether any amount is withheld from an employee's wages. Might also include additional voluntary insurance such as long-term disability.
7. Records — Includes all documentation and data maintained relative to the employees of an institution.
8. Employee Health Service — Relates to the special function within the institution for the purpose of maintaining, diagnosing and treating the health care of employees.
9. Safety — Relates to construction features, devices, policies, procedures, and rules which are designed to protect employees from injuries or from disease in the course of the discharge of their responsibilities.
10. Hiring — Relates to institutional policies, procedures and practices in the process of recruiting and engaging new employees.
11. Discrimination — Relates to those policies, procedures and practices designed to insure that the civil rights of employees and/or prospective employees are not violated.
12. Dress Code and Uniforms — Relates to those institutional rules, regulations, policies, and practices which direct how employees are to be attired and whether special apparel is to be provided by the institution.
13. Fair Labor Practices — Relates to that broad category concerning the relationship between the management of an institution and its other employees.
14. Training — Anything concerning the education of employees in the conduct of their jobs. Includes: in-service education, on the job training, and similar formal or informal programs. Does not include tuition aid programs offered by the institution as a fringe benefit.
15. Supervision — Anything concerning the management or direction of the activities of employees in the discharge of their responsibilities.
16. Volunteers — While volunteers are not employees, they are included in this major area of regulation because certain rules of regulatory bodies which relate to age, hours of service, etc., also apply to the personnel function within the institution.

95-195 O - 77 - pt. 2 - 30

SUPPORT SERVICES

1. Purchasing — Shopping and contracting for the acquisition of goods and services for the institution falls under this function. Special technical knowledge is frequently required. Does not include receiving, warehousing, and distribution of materials purchased.
2. Material Usage — Pertains to the receipt, storage and internal distribution of goods used by an institution as well as to the manner in which such goods may be administered and/or utilized.
3. Food — All materials used to meet the nutritional requirements of patients, employees and others. Does not include intravenous solutions and other nutrients which are not consumed by the patient in the processes of eating or drinking. Includes all activities relating to the acquisition, storage, preparation and serving of both solid and liquid foodstuffs.
4. Laundry — Relates to the cleaning, ironing, and other preparations for reuse of bed linens, uniforms, towels, drapes and covers, etc., whether any or all of these processes are conducted within the institution using owned equipment or by utilizing the services of an outside contractor.
5. Communications — Telephones, intercoms, paging, mail, messengers, C.B. radios, etc., all represent areas which relate to the communication functions of a health care institution. The function includes communications within the institution as well as with individuals and organizations external to the facility.
6. Transportation — The functions of carrying people as well as goods to or from the facility falls within the area of transportation. Specific activities might range from arranging for taxi service for patients to bussing employees or patients to trucking materials to or from the facility.
7. Security — The in-house police force activity. Includes: peace keeping, crowd control, crime prevention, traffic control, etc. All of these are included in this function. The most common job title in this functional area would probably be "guard."
8. Package Control — A function relating to Security is that of controlling the movement of packages into and out of the facility. Such packages might be carried by patients, visitors, employees, truckers, etc.

APPENDIX C

to the

REPORT OF THE

TASK FORCE ON REGULATION

Elwood A. Opstad, *Chairman*
Huntington Hospital
Huntington, New York

William D. Barclay
DeGraff Memorial Hospital
No. Tonawanda, New York

Michael O. Bice
Geneva General Hospital
Geneva, New York

Joseph L. Bloch
Peninsula Hospital Center
Far Rockaway, New York

Douglas R. Brown
Sloan Institute of Hospital
Administration, Cornell Univ.
Ithaca, New York

Charles G. Herbermann, Jr.
Yonkers General Hospital
Yonkers, New York

Sue Kennedy
F.F. Thompson Hospital
Canandaigua, New York

Staff: John R. Garrison, Secretary
Paul Morton Ganeles
Andrew Foster

Harvey Machaver
Hospital for Joint Diseases
New York, New York

Edward A. Messier
St. Luke's Hospital Center
New York, New York

Lucia Millham
Community Hospital at Glen Cove
Glen Cove, New York

Jason K. Moyer, M.D.
Binghamton General Hospital
Binghamton, New York

William E. Philion
Glens Falls Hospital
Glens Falls, New York

Peter B. Terenzio
Roosevelt Hospital
New York, New York

Joseph F. Turner
Western New York Hospital Assn.
Buffalo, New York

APPENDIX D

to the

REPORT OF THE

TASK FORCE ON REGULATION

AD-HOC SUBCOMMITTEE TO INVENTORY REGULATIONS

Maurice Cohen
Peninsula Hospital Center
Far Rockaway, New York

Terry Daly
Nassau Hospital
Mineola, New York

John Davanzo
New York Infirmary
New York, New York

Jack Hoard
Genesee Hospital
Rochester, New York

Frederick Lang
Beekman-Downtown Hospital
New York, New York

Ronald Mullahey
Geneva General Hospital
Geneva, New York

Robert D. Reisch
DeGraff Memorial Hospital
No. Tonawanda, New York

Paul Tasello
Binghamton General Hospital
Binghamton, New York

AGENCIES IDENTIFIED IN THE

REPORT OF THE TASK FORCE ON REGULATION

FEDERAL

Department of Health, Education and Welfare

Office of Consumer Affairs
Office for Civil Rights
Education Division
Public Health Service:
- Surgeon General
- Office of Population Affairs
- Office of Equal Employment Opportunity
- Office of Professional Standards Review
- Office of Nursing Home Affairs
- Center for Disease Control
- Food and Drug Administration

Health Resources Administration:
- Division of Long Term Care
- Bureau of Quality Assurance

National Institutes of Health
Alcohol, Drug Abuse, and Mental Health Administration
Office of Child Health Affairs
Office of Human Development:
- Administration on Aging
- Office of Child Development

Bureau of Health Insurance
Social and Rehabilitation Services:
- National Center for Social Statistics
- Rehabilitation Services Administration
- Medical Services Administration
- Office for Handicapped Individuals

Social Security Administration:
- Bureau of Disability Insurance
- Bureau of Retirement and Survivors Insurance
- Bureau of Supplemental Security Income

Other Federal Departments

Agriculture, Department of
Commerce, Department of
Defense, Department of
Energy Research and Development Administration
Environmental Protection Agency
Equal Employment Opportunity Commission
Federal Communications Commission
Interstate Commerce Commission
Justice, Department of
Labor, Department of
National Labor Relations Board
Postal Service
Transportation, Department of
Treasury Department
Veterans Administration

STATE

New York State Department of Health

Birth Defects Institute
Bureaus and Offices of:
- Acute Communicable Disease Control
- Ambulatory Care
- Architectural and Engineering Services
- Biostatistics
- Cancer Control
- Chronic Disease and Geriatrics
- Controlled Substances Licensing
- Dental Health
- Economic Analysis
- Emergency Health Services
- Facility Planning
- Family Planning
- Health Care Reimbursement
- Hospital Certification
- Hospital Construction Financing
- Hospital and Institutional Engineering
- Heart Disease Control
- Maternal and Child Health
- Medical Manpower
- Medical Rehabilitation
- Medicare Program Coordination
- Milk and Food Sanitation
- Narcotics Enforcement
- Nursing Home Administration
- Nutrition
- Professional Medical Conduct
- Program Planning and Analysis
- Provider Audit
- Public Water Supply
- Radiologic Technology
- Radiological Health
- Rehabilitation Therapies
- Residential and Recreation Sanitation
- Rodent Control
- Tuberculosis and Hypertension Unit

Burns Care Institute
Clinical Laboratory Center
Environmental Health Center
Hospital Nursing Services
Infectious Disease Center

Other State Departments

Audit and Control, Department of
Office for the Aging
Agriculture and Markets, Department of

Other State Departments *(continued)*
Board of Social Welfare
Civil Service, Department of
Crime Victims Compensation Board
Dormitory Authority
Division of Human Rights
Office of Drug Abuse Services
Education Department:
- Office of Higher and Professional Education
- Office of Vocational Rehabilitation
- Board of Examiners (Pharmacy)

Department of Environmental Conservation:
- Office of Environmental Analysis and Permits
- Division of Air Resources
- Division of Pure Waters
- Division of Quality Services
  - Bureau of Radiation
  - Bureau of Noise
- Division of Solid Waste Management
- Emergency Fuel Office
- Division of Housing and Community Renewal
- New York State Higher Education Services Corporation

Insurance Department
Department of Labor:
- Affirmative Action Program
- Equal Employment Opportunity Office
- Investigation Section
- Labor Standards Division
- Manpower Planning Secretariat
- Research and Statistics Division
- Safety and Health Division
- Unemployment Insurance Division

Department of Law
Department of Mental Hygiene:
- Division of Alcoholism
- Division of Mental Health
- Division of Mental Retardation and Childrens Services
- Division of Standards, Inspections and Program Evaluation
- Office of Facilities and Capital Services

Motor Vehicles, Department of
Public Service Commission
Department of Social Services:
- Adult and Family Services
- Children's Services
- Division of Medical Assistance

Department of State:
- Community Affairs and Planning Group
- Corporation and State Records Division
- Division of Economic Opportunity
- Division of Fire Prevention Control
- Division of Licensing Services

State Board of Equalization and Assessment
State Insurance Fund
State Liquor Authority
Department of Taxation and Finance:
- Corporation Tax Bureau
- Income Tax Bureau
- Sales Tax Bureau

Transportation, Department of
Workmen's Compensation Board
Division for Youth

County/City

Health Department
Social Services, Department of
Board of Mental Health
New York City Bureau of Handicapped Children
New York City Drug Addiction Service
New York City Department of Human Resources
New York City Human Rights Commission
Maternal and Child Health Council
Highways, Department of
Tax Collector
Police Department
Fire Department
Water and Utility Department
Sanitation Department
Building Department
Zoning Board
New York City Department of Air Resources
New York City Department of Environmental Control

Quasi-Public

Health Systems Agencies
Professional Standards Review Organization
Regional Planning Agency

Voluntary

American Association of Medical Colleges
Blue Cross Plans
Council of Teaching Hospitals
Factory Insurance Association
Insurers — Various
Joint Commission on Accreditation of Hospitals
National Board of Fire Underwriters



STATEMENT OF

THE HOSPITAL ASSOCIATION OF PENNSYLVANIA

TO THE

SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH

OF THE

SENATE COMMITTEE ON HUMAN RESOURCES

ON

S 1391

THE HOSPITAL COST CONTAINMENT ACT OF 1977

* * *

The Hospital Association of Pennsylvania, on behalf of its 325 member institutions, is pleased to have this opportunity to submit written comments on S 1391. Now in our 56th year, the Association is comprised of virtually all of the 240 community hospitals in Pennsylvania as well as over 80 institutions offering specialized care, long term care and primary care.

Our Association is strongly opposed to this legislation. We believe that its enactment would seriously jeopardize the present and future ability of Pennsylvania hospitals to provide services to sick people. This Bill is badly designed, wrong in concept, unfair, and impossible to administer. The Bill deals with only one aspect of an extremely complex and interdependent system of providing

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health services to the citizens of our nation. The Administration obviously has singled out hospitals because they account for 40% of total health care costs and their rate of cost increase (approximately 15% last year) is consistently the highest in the health care field.

The fact that nationally and in Pennsylvania hospital and health care costs in general are increasing at a rapid rate is not in dispute. What is disputable is the Administration's claim that vast sums of money can be saved by increasing the effectiveness and efficiency of hospitals, thereby providing more health care services for less money. The hospital industry deeply resents the implication that because health care costs are increasing, hospitals are inefficient, wasteful, mismanaged, and unconcerned about costs. The truth is that there are many significant factors affecting costs which are beyond the control of the individual hospital; those that are controllable are being addressed aggressively by the hospitals of our state. An analysis of hospital costs in Pennsylvania is included as Appendix A. This document states clearly why hospital costs are rising.

The architects of the Administration's Bill have chosen either to ignore or to misinterpret some of the key issues in health care today, the status of current control systems, and the dynamic trends that are taking place in hospitals. It is also possible the Administration does not understand the health care system.

Mere introduction of this Bill already has had a palling effect on some of the progressive activities occurring in Pennsylvania hospitals. To cite some examples:

a) The Philadelphia General Hospital is closing. No longer will this 803-bed major community institution be providing

service to an average 680 inpatients per day. These patients must be shifted to other institutions. In addition, since Philadelphia General has provided services to over 100,000 outpatients annually, a significant question is raised as to who will take care of these outpatients. It must be recognized that this hospital is closing because it serves principally patients in an inner-city area who do not have adequate money to pay for health care, and Medicaid patients for whom payment by the State of Pennsylvania has been woefully inadequate. Plans are now underway to have all patients transferred to surrounding institutions, but the hospitals which accept these patients will be severely penalized by certain provisions of S 1391.

b) In the Harrisburg area, nine hospitals have been meeting regularly to determine how excess acute bed capacity can be eliminated, certain services shared, certain services centralized, and new services developed where there are unmet needs. Some of the issues under discussion include development of specialized and centralized services for burn care, neonatal intensive care, psychiatry, home care, drug addiction and alcoholism, and new forms of ambulatory care. These discussions are now at a standstill because the Administration's Bill will financially penalize hospitals that take on the high-cost services and reward those that either take on the less expensive services or diminish services.

c) The Scranton State General Hospital and the Community Medical Center in Scranton are committed to merge. Scranton State has just been notified that under Section 223 of Public Law 92-603, the hospital has exceeded the 80th percentile and must pay a penalty of $432,675. Coupled with the uncertainties of the Administration's

Bill, this turn of events may delay or even prevent this very desirable merger from taking place, even though knowledgeable health authorities all have recommended that it be done.

d) Fifty-eight hospitals in Pennsylvania currently operate schools of nursing. During the Economic Stabilization Program, fourteen hospital schools closed in Pennsylvania. Administrators in many hospitals tell us that under S 1391, nursing schools would be among the first areas of cost to be eliminated.

e) Thirty Pennsylvania hospitals currently provide 80% of the service to Medicaid recipients in the state. These hospitals are located principally in the inner-city areas of Philadelphia and Pittsburgh. Many of these hospitals are approaching bankruptcy because of the way the Medicaid program operates in Pennsylvania. For example, the Medicaid program pays hospitals $6.00 or $9.00 per visit for outpatient care for eligible recipients, regardless of the cost of that care -- which averages well over $20.00 per visit in Pennsylvania. In addition, because of severe income limits imposed on participants in the Medicaid program, a significant number of people are ineligible, although they are, in fact, medically indigent. Consequently, because of the free care these 30 hospitals provide these persons, they are experiencing substantial deficits. Without question, the Administration's Bill will force these hospitals to reduce substantially their current level of charity care in order to remain solvent.

Pennsylvania hospitals have endorsed and are supporting:

a) Public Law 92-603, Title XI of the Professional Standards Review Act. This Act calls for groups of local physicians in defined geographic areas to assume the following responsibilities:

1) to develop standards of what care is appropriate to deliver to a particular patient in a specific setting; 2) to see that care provided in a region and paid for with tax dollars is compatible with standards and is provided in the most appropriate setting; 3) to see that standards are modified as appropriate; and 4) to take appropriate action in instances where care is provided outside those standards. This legislation is working well in Pennsylvania. Length of stay in acute general hospitals has decreased from an average 9.1 days in 1972 to an average of approximately 8 days in 1977; and

b) Public Law 93-641, The National Health Planning Resources and Development Act of 1974 -- which provides the foundation for coordinating the nation's health care delivery system. By 1978, all capital expenditures of health care facilities will be required to relate directly to the needs and priorities set by the planning agencies established under this Act. Given adequate funding, this statute provides the basic structure for controlling capital improvements of health care facilities. The Act requires that each state have a certificate of need program that meets certain federal requirements and standards by 1980. There has been significant progress in Pennsylvania during the last six months in this regard, and there is every indication this progress will continue if the program is properly funded. This Act must serve as the primary mechanism for determining capital improvements for the health care industry.

Many of the accomplishments now being implemented under these two major pieces of legislation will come to a halt because of the Administration's Bill. The reason is that some of the changes generated by these laws are causing disproportionate cost

increases in some hospitals, and S 1391 will penalize hospitals for making these changes. Consequently, decisions will be made solely on the basis of reimbursement, not on the basis of what is best for the community or the health care delivery system. In this sense, it is extremely unfortunate that the Administration has chosen to introduce this Bill rather than to endorse and adequately fund these two major pieces of legislation that can get at the real issues in health care delivery and cost.

Our specific comments on S 1391 are as follows:

a) Inpatient Revenue Limit -- The basic method for setting the total hospital revenue limit and the formula used to calculate the limit are unfair and will cause some serious operational problems for many Pennsylvania hospitals. One of the most important lessons everyone learned from the Economic Stabilization Program was that all hospitals are not similar; that critical factors occur each year that change the patient characteristics and services of the institution -- many of these factors beyond the control of the hospital; and that any control system must be structured to recognize these individual differences and to permit exceptions to the basic formula for appropriate reasons.

We find serious problems with application of the basic control formula. Virtually all hospitals in Pennsylvania are on a June 30 fiscal year; consequently, the first application of the controls would be retroactive to hospitals' fiscal years beginning after October 1, 1976. Therefore, if passed, these controls would apply retroactively. Such retroactivity simply sacrifices equity in order to meet the Administration's budget target for fiscal year 1978, regardless of its impact on hospitals.

An adjustment to the Bill's basic formula is provided by the "Admission Load Factor", which would allow for modifications in revenue limits reflecting changes in admissions between the base year and the controlled year. Unfortunately, this adjustment incorrectly assumes that hospitals can accommodate up to 2% additional admissions without need for increased revenues to cover the costs added by the admissions. In addition, admissions above 2% would be reimbursed at the rate of one-half the average cost of an admission. The assumption is that increased admissions to a hospital are to be deterred, even though the increased occupancy of the hospital can be an important way to improve its effectiveness.

One of the most significant changes now occurring in hospitals is centralization of high-cost services such as burn care or neonatal intensive care -- in one institution. As suggested earlier, if such centralization is accomplished, the hospital which provides this care very likely will increase its admissions by less than 2%, but the cost increase will be dramatic. Thus, the hospital that agrees to assume this important new responsibility will be penalized. If, because of other circumstances, the hospital's overall admissions increase in excess of 2% then the penalty is compounded.

The Administration's Bill theoretically is designed to discourage inpatient utilization and encourage outpatient utilization; but this goal will not be accomplished in Pennsylvania. Pennsylvania hospitals annually experience about a $35 million loss in providing outpatient services to Medicaid recipients. In addition, many hospitals also provide significant charity care to persons who do not have adequate resources to pay for that care, but whose income is above the eligibility limit of the Medicaid program.

Since inpatient revenue from commercial insurance carriers and self-paying patients is being used to offset the inadequate outpatient payments, the Administration's Bill indirectly forces these hospitals to initiate dramatic cutbacks in outpatient service in order to stay within the inpatient limits.

Under the Bill, total hospital revenue is to be contained by limiting increases in revenues for inpatient services from all types of payers through a limitation on increases per admission, by class of purchaser. The Bill ignores the way hospitals are currently paid, as well as many of the contracts currently in effect. Today in Pennsylvania, 80% of hospitals' revenue is on a cost basis, except that by law Medicaid is prohibited from paying more than Medicare.

As an example of the present reimbursement system, consider the following figures from The Harrisburg Hospital, Harrisburg, Pennsylvania. Assume the patient was hospitalized for eight days. Using three different years for comparison, here is how the hospital was paid by various payers:

Typical 8-Day Patient Stay

	1970	1974	1975
Cost/stay	$623.56	$817.06	$899.30
Reimbursement/stay:			
Blue Cross	528.19	693.93	761.58
Medicaid	520.85	748.41	747.01
Medicare	513.52	692.22	734.75
Commercial and self-pay	733.60	961.25	1,058.10
Total charges/stay	733.60	961.25	1,058.10

What are the significant relationships of these financial data?

1) Reimbursement from Blue Cross, Medicare, and Medicaid is less than the institution's full cost.

2) Charges are equal to commercially-insured and self-pay reimbursement, and these charges are significantly higher than cost.

3) The commercially-insured and self-pay patients subsidize all other categories of reimbursers in order for the financial needs of the institution to be met, and particularly so that this institution can carry out its responsibilities in providing charity care and care to patients who can afford to pay only part of their bill.

Here is another example. Eleven hospitals in Pennsylvania recently have been notified by the Federal Bureau of Health Insurance that they have exceeded the limitations on inpatient routine service costs as provided under Section 223 of P.L. 92-603. (Last year nine institutions were notified that they had exceeded the 90th percentile). Each of the hospitals notified will be penalized in the amount beyond the 80th percentile limit for the fiscal year 1975-76. This penalty, in effect, permits Medicare and Medicaid to pay less than the institution's cost simply because of an arbitrary formula which has no regard for the specific operating characteristics of these eleven institutions during the particular fiscal year. Consequently, the Administration's Bill would penalize these institutions again, since it would allow for a maximum increase in Medicare and Medicaid payment of 9% regardless of the reason for limitations in payment during the previous year.

In effect, the Administration's Bill basically endorses the inequities in the present payment system when most knowledgeable health authorities now are convinced that it would be less costly, more equitable and most beneficial to the entire nation if all payers were required to pay the same price for the same service at the same hospital. Experiments are under way in Pennsylvania to try to implement this approach. The most notable effort is in Pittsburgh, where a pilot prospective reimbursement project involves over thirty hospitals. The Administration's Bill will discourage all such experimental efforts along these lines and will serve to undermine one of the most important trends in the industry.

b) Exceptions -- By its own admission, the Administration does not anticipate exceptions to be allowed under this legislation. The requirements for an exception are so strict that a hospital must be on the verge of bankruptcy before an exception can be granted. Requiring hospitals to liquidate unrestricted investments, such as stocks and bonds, before being eligible to apply for an exception will eliminate philanthropy. No one is going to donate money to an institution merely to meet day-to-day operating expenses.

One of the most important single lessons to be learned from the Economic Stabilization Program is that any national control system affecting hospitals must be designed to recognize the individual operating characteristics of hospitals and the unusual situations that occur during any fiscal year. Most importantly, it must permit exceptions for proper cause. Every section of S 1391 dealing with exceptions is so badly written that we resent commenting on it. The authors of this legislation simply refuse

to recognize that a simple formula applied to all hospitals doesn't work, and that when you try to apply such a formula the only possible alternative is to have a fair exceptions process.

c) Implementation and Enforcement -- Under the Bill, it would be impossible for hospitals to be assured ahead of time what they would need to be in compliance with the Act. Hospitals and payers would not know if they are in compliance with the provisions of the Bill until year-end fiscal settlements affecting the base year are made. (The Medicaid program in Pennsylvania, for example, makes year-end settlements approximately twelve months after the close of a fiscal year.)

Because hospitals would not know what their future would hold, they would be encouraged to include a safety factor in their charges and to hold the income from that safety factor in escrow -- since if revenues were short they otherwise would be unable to collect the additional allowable amount on claims already settled with charge payers. The Bill also would tend to undermine the aggressive development of better budgeting and cost containment techniques which Pennsylvania hospitals are pursuing.

d) Limitation on Hospital Capital Expenditures -- It is significant that during the same week the Administration introduced this Bill, HEW Secretary Joseph Califano signed regulations prohitibing discrimination against handicapped individuals by recipients of HEW funds. Allowing no exceptions, the regulations specify that structural changes must be made within three years to enable all facilities to be easily accessible and usable by the handicapped. The American Hospital Association has estimated that hospitals will have to spend some $880 million over the next three years just to comply with these regulations. Two years ago, the same thing

95-195 O - 77 - pt. 2 - 31

happened when HEW arbitrarily mandated that all hospitals providing service to Medicare and Medicaid patients meet the strict requirements of the 1967 Life Safety Code. Compliance with the Life Safety requirements ultimately will cost Pennsylvania hospitals approximately $500 million, with questionable improvement in patient care and safety.

The proposed arbitrary limit on capital expenditures completely ignores Public Law 93-641 and all of the effort that has gone into making that legislation effective. Local planning agencies and hospitals not only would be subject to the normal controls of P.L. 93-641 but also would have arbitrary limits applied without regard to the special characteristics of each area.

Even more disturbing is that capital expenditures approved under Title II are not automatically reflected in pass-throughs for the higher operating expenses that would result. For while Title I of the Bill does provide for an exceptions procedure -- albeit an unsatisfactory one -- hospitals implementing projects approved under Title II could not get revenue adjustment exceptions unless the cost impact of the projects otherwise would endanger their solvency. This additional risk would increase interest rates paid by hospitals for capital expenditures.

Alternative Considerations:

a) A major decision must be made by the public and government as to the quantity and level of health care services they want and are willing to pay for. If the choice is to limit our nation's investment in its health care system because it is too costly, then the public must be prepared to reduce its expectations from the system as well. The delivery of health care services involves many

sensitive, complex, emotional, social and financial aspects of our society. Any approach to controlling health care expenditures must apply to the entire health care industry and must have major support and participation by government, industry, labor and consumers, as well as by all elements of the industry.

b) Government regulation is responsible for a very significant part of the continuing increase in hospital cost, and drastic reform is necessary. The Hospital Association of Pennsylvania recently completed a massive report on the impact of government regulations on hospital costs. (A summary of that report is attached as Appendix B.) The report details very carefully many of the critical issues that must be addressed, and substantial evidence is available to support the conclusions. In the event you would like a complete copy of the full report, we would be happy to furnish it.

The overwhelming dilemma of the hospital industry on this entire subject can be crystallized by describing two meetings held in Pennsylvania during the last three weeks. One was with the Secretary of the State Department of Public Welfare and the other with the Secretary of the State Department of Health. The Department of Public Welfare operates the Medicaid program in Pennsylvania and is deeply concerned about increasing hospital and medical care costs. The Secretary has requested our assistance in identifying and initiating activities that could effectively contain cost. The Department of Health, on the other hand, determines whether a hospital is licensed or approved to operate in Pennsylvania. The Department recently published new proposed rules and regulations for hospitals in the state. Our Association estimates that, if adopted, these new rules and regulations will have a dramatic impact on these same hospital costs the Welfare Department is concerned about. These kinds of conversations occur every day, with

one set of discussions totally committed to cost containment and the other directed at improved patient care and more services. Please read carefully our recommendations in this very important area. (Appendix B)

c) There are three principal methods for controlling hospitals' costs: (1) by controlling utilization, (2) by controlling planning and capital expenditures, and (3) by controlling operating expenditures. It is our contention that P.L. 92-603 is controlling utilization and that P.L. 93-641 is controlling planning and capital expenditures effectively. We also have experienced many attempts to control hospital operating expenditures, including: (1) the Economic Stabilization Program; (2) reimbursement limitation for certain beneficiaries under Sections 223 and 224 of Public Law 92-603; (3) Medicare and Medicaid reimbursement formulas; (4) Blue Cross contracts; and (5) hospital rate regulation in some states. The experience with all of these approaches has been unsatisfactory because they tend to treat the hospital as an entity separate from the other elements of the health care delivery system and from the other factors causing inflation.

To conclude, the Administration's proposed legislation is so bad that it must be opposed in its entirety. Introduction of this Bill at this time is extremely unfortunate because it undermines some of the important and necessary changes occurring in the industry, encouraging hospitals to delay instituting significant cost-saving activities for fear they will be penalized if the legislation is adopted.

jr
5-23-77

THE HOSPITAL ASSOCIATION OF PENNSYLVANIA

AN ANALYSIS OF HOSPITAL COSTS IN PENNSYLVANIA

FIRST, A CAUTION

A significant problem in analyzing hospital costs is finding an appropriate unit of statistical measurement. The hospital industry continues to report cost data on the basis of "cost per day" for consistency, and for the lack of a better alternative. However, we wish to caution that these figures can be misleading because they only measure costs on the basis of days spent in a hospital. If an institution has exactly the same expenses and admissions this year as last year, but because of new surgical procedures some patients were able to reduce their stays in the hospital, the same costs would be spread over fewer days of care, and the result would be an increase in the "cost per day" figure. Admittedly, this is an oversimplification since the hospital product is constantly changing as a result of new technology, new medicines, new procedures, and different methods of treating patients, to cite a few reasons.

If an item costs $1.00 this year and $1.10 next year, it is reasonable and accurate to say that the price of the item increased 10%. However, if the item has been changed in some manner -- size, or material, or design, or quality for example -- can we still say the price increased 10%, or are we not talking about a totally different item, thus precluding this type of comparison? A "patient day" is a day of care in a health care

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institution. However, it should be apparent that a day of maternity care differs significantly from a day of care for a patient who has had open heart surgery; yet the "cost per patient day" unit of measure does not reflect the shifting nature of patient days and associated costs.

As the subject of rising costs assumes increasing national importance, it is essential that the data upon which future public policy decisions are to be based be as authoritative and as detailed as possible. To that end, our Association is cooperating with the American Hospital Association in the development of two statistical indices, the hospital input price index, and the hospital intensity index which we believe improve upon existing statistical indices used to demonstrate the reasons for increases in hospital expenditures. These indices will be published monthly by the American Hospital Association and we will also be able to provide specific data for Pennsylvania. We think this will prove to be a useful tool in assisting all of us in achieving a better understanding and, therefore, developing a better explanation as to why hospital costs are increasing.

The data appearing in this analysis were developed from monthly reports generated for Pennsylvania hospitals by the American Hospital Association and covering the 12-month period ending June 30, 1976.

During that period, the average cost per day in Pennsylvania hospitals rose 15.7%, just slightly ahead of the national average of 15.2% The average cost per case in Pennsylvania hospitals increased 14.9%, percentage of hospital bed occupancy rose 1.3%, and the average length of stay decreased 0.6 percent, or one-tenth of a day.

PERSONNEL COSTS

Of the 15.7% cost per day increase in Pennsylvania, more than half - 8.7% - is directly attributable to increased personnel costs. These increases can be further broken down into salary increases of 5.1%, added fringe benefit costs of 1.0% and an increase in the number of employees, reflecting 2.6% of the increased costs.

Hospitals spend approximately 51% of their budget on employee wages, while other industries spend a considerably smaller proportion of total budget. The nature of hospital service - care of the ill and injured - necessitates a person-to-person relationship; therefore, the hospital industry must employ large numbers of people (an average of 3.26 employees per patient), as opposed to private industry which relies heavily on automation. Because of the number of persons employed by hospitals, and the degree of specialized training they require, wage increases have a much greater impact on hospitals than on other industries. These factors, coupled with a significant increase in union activity and the necessity of keeping wages of hospital workers competitive with other industries in the community have contributed to increased payroll costs.

Hospital wages, which for years were notoriously low, had begun to catch up with the rest of the economy until the economic stabilization program was begun in 1971, and wages were frozen at an average 5.5% increase annually for the next three years. Indeed, for about a year after controls were lifted from most of the rest of the economy, they remained in place for the health care industry. So, while the cost of living was increasing at record rates, hospital workers' wages were being depressed. Since wage and price controls were lifted for hospitals in April of 1974, there has been a moderate "catching up" period for employees, in an attempt

to regain some degree of equity with workers in other fields. Recent data suggest that more pressure will be felt in this area. For example, medical or supportive service employees of the Pennsylvania government have average salaries of $11,101 and a significantly better fringe benefit package which places them over 20% higher than hospital employees with similar training.

Higher wages also bring attendant increases in fringe benefits through payment of higher Social Security taxes, increased workmen's compensation taxes, increased premiums for health care insurance, and increased retirement contributions (due in part to the Pension Reform Act). New fringe benefits also have been added to attract and retain qualified personnel.

Other increases in personnel cost have been due largely to the hiring of additional employees (2.6% of the increase) in both patient and non-patient care areas. Many of these additional employees are directly related to the changing role of the hospital and the type of patient being treated. There was a time when the function of a hospital was more one of care than of cure. This custodial function called for employing personnel with a minimum of training and skill and permitted hospitals to employ persons from lower levels of the labor market as the bulk of their work force.

The introduction of new patient care techniques, diagnostic equipment and other medical advances has required a constant upgrading of the quality and an increase in the number of hospital employees. The miracles of modern medicine, demanded by a sophisticated public, have added heavily to the payroll costs for hospitals.

Today's modern hospital may have more than 200 different job classifications. Many of the employees have special skills that command relatively high salaries. On the average, one of every three hospital employees has specialized training, and most employees require special orientation and training on a continuous basis.

In the past ten years alone, dozens of new job titles have been created. These include respiratory therapist, surgical technician, cardiopulmonary technician, catheterization technician, nuclear medical technologist, electromedical equipment repairman, heart-lung machine operator and numerous other technicians and technologists. Nursing, too, has become more specialized because hospitals are offering more intensive care for the heart attack patient, for the critically ill medical-surgical patient, and for infants born with life-threatening problems.

The patient who is admitted to an inpatient service requires more intensive treatment than did his counterpart of several years ago. The number of x-rays, laboratory tests, physical therapy treatments and other ancillary services has increased by up to 25% during the past year alone. To adequately meet the increasing demand for these services, additional persons have been employed. While some of these treatments may be the result of "defensive medicine" practices, the majority have been used to maximize the certainty of diagnosis or the effectiveness of treatment, thereby minimizing danger to the patient.

The addition of some employees is a direct result of the increased record-keeping and data-generating requirements mandated by both governmental and voluntary agencies. Development of utilization review, quality assurance and Professional Standards Review Organizations has led to personnel increases in both medical records and social services. The

large amount of information and data which must be provided to third party payers for the purposes of reimbursement, accreditation, and licensure has necessitated additional personnel in data processing and financial management. Finally, the deterioration of many urban areas has required hospitals in those areas to increase security personnel to protect both employees and patients.

Unlike most industries, hospitals must be staffed to provide services 24 hours a day, 365 days a year; and they must always be staffed at a specified level, with trained personnel available when needed. There is no such thing as a seasonal layoff should the patient census dip temporarily.

In addition, increases in personnel costs can be directly attributed to government law or regulation. For example, hospitals are now covered by the Fair Labor Standards Act, National Labor Relations Act, Equal Employment Opportunity Laws, Federal Unemployment Compensation Amendments, and the Employees Retirement Security Act. While most other industries are similarly covered, significantly more impact is shown in the health care industry because of its higher labor intensity.

OPERATING COSTS

With about 8.7% of the 15% increase in hospital costs from 1975 to 1976 going for personnel-related items (salaries, fringe benefits, etc.), the other 7.0% can be accounted for in increased operating costs - principally in the areas of supplies and services (2.9%), capital expenditures for equipment (1.8%), capital expenditures for physical plant (2.0%) and interest

expense (about 0.3%).

Increases in fuel and electricity costs continue to occur despite aggressive fuel energy conservation programs instituted by many hospitals which have resulted in less energy consumed. Likewise, where inpatient days have decreased, the actual number of meals served obviously has decreased; yet overall food costs have increased. Drug cost increases have resulted largely from both a greater use of medications and the higher purchase prices most hospitals have had to pay. These increased purchase prices are in part attributable to the increase of all petroleum-derivative pharmaceuticals. Telephone charges also have increased since hospitals lost their "charitable discount" status in 1974. Finally, despite the efforts of most hospitals throughout the state to hold costs down through effective loss control programs, and through the establishment of their own captive insurance company, malpractice insurance rates nevertheless have skyrocketed.

Capital expenditure for equipment is another major cost of providing hospital care. The constantly changing technological environment, intensity of illness, and public demand have prompted increased capital outlays. The total cost of equipping an average operating room is $20,000 or more. A television monitoring system, for instance, allowing the x-ray department to view and diagnose from x-ray pictures originating in surgery, costs $3,000. The ultrasonic cleaner used to clean various surgical utensils, costs over $4,500; an autoclave, also used in sterilizing equipment, costs over $5,700; an operating room table, over $4,400; surgical lights for the operating room cost over $5,800.

The total cost for buying intensive care unit equipment and installing the equipment can easily exceed $12,000. This figure includes a $2,300 defibrillator and oscilloscope, a $200 suction machine, a $1,300

electrocardiograph, a $100 portable oxygen machine, a $4,300 automatic respirator, and a $3,700 "crash cart" complete with synchronized direct current defibrillator, oscilloscope, internal-external pacemaker, and ECG machine. Equipment costs become much more pronounced in highly specialized areas. For example, the initial cost for facilities and all equipment in a ten-bed kidney dialysis center has been estimated at over $300,000; a cardiac catheterization lab can cost over $250,000; and a highly sophisticated radiology department can cost well over $1,000,000.

However, not all equipment is purchased to provide a more sophisticated level of care. Some machines, particularly in the laboratory areas, are designed to increase efficiency. For example, the coulter counter blood machine automatically counts white and red blood cells, measures hematocrit and hemoglobin, calculates three other items about red blood cells, and prints the results on a computer card - all in forty seconds. The same procedure by hand would take twenty to thirty minutes. The machine costs over $35,000.

The prime goal of medical care is to save lives and ease suffering, and to that end science has developed and is developing amazing new methods of treatment. Of necessity, this rapid progress has been directed towards increasing the sophistication of care. To that end, technology continues to strive.

Legislation, too, has created additional operating cost burdens for health care institutions. Examples include:

Occupational Safety and Health Act of 1970 - This law was enacted to assure " ... every working man and woman in the nation, safe and healthful working conditions ...". All employers are required to provide employment conditions that are free from hazards which might cause death or serious physical

harm and to comply with the safety and health standards promulgated under the act. The OSHA standards presently include hundreds of pages of printed material encompassing thousands of detailed matters. These standards include, but are not limited to, the following areas: housekeeping; aisles and passageways; floorloading protection; means of egress; fire protection; sanitation; electrical requirements; protective equipment for personnel; accident prevention signs and tags; and laundry machinery and operations. The cost of complying with these standards and maintaining the proper records and documentation to monitor compliance imposes an additional expenditure of limited health care resources.

Life Safety Code Requirements - Titles XVIII and XIX of the Social Security Act require all hospitals to be in compliance with the 1967 Life Safety Code as a condition for participation in these federal programs. However, hospitals receiving grants or loans under the Hill-Burton Act must comply with the 1973 Life Safety Code. If a hospital has a skilled nursing facility, the skilled nursing facility must be in compliance with the 1973 Life Safety Code to be approved for participation in the Medicare program while the rest of the hospital must still comply with the 1967 Life Safety Code. Finally, hospitals also must comply with a wide variety of differing state and local fire and safety codes. As a result of conflicting and differing standards/procedures of these codes, some hospitals have spent thousands of dollars to maintain compliance under one code only to have been found out of compliance when a new code or amended standard has been adopted.

The enormous outlay required to keep pace with technology and maintain existing facilities has required that hospitals borrow significant sums of money in recent years. Interest costs on these loans have also

contributed to the rising costs per patient day in Pennsylvania.

COST CONTAINMENT ACTIVITIES

Although many cost areas are out of an institution's control, hospitals are doing their best to economize in areas which are under their control, without sacrificing the quality of the care they provide.

One area includes intensified programs of ongoing utilization review activities to assure that unnecessary admissions are not being made, and that hospital stays last no longer than necessary. The system also takes into consideration whether or not the treatment being provided is proper and consistent with the diagnosis, and whether any unnecessary treatment or tests are being ordered.

Hospitals continue to pursue their emphasis on outpatient or "vertical" care, through same-day surgical services, expanded outpatient departments, coordinated home care programs, and testing of elective surgery patients on an outpatient basis prior to admission for surgery. These programs - and others like them - are designed for more appropriate and effective delivery of care, with resulting reductions in the overall cost to the public. The increasing trend toward coverage of such outpatient services by insurance companies is encouraging, but there is potential for even more significant savings in this area.

Another area of cost saving by hospitals comes through participation in regional efforts such as group purchasing cooperatives for food, medical supplies and the like; and in the development of shared laundry services at strategic geographic locations. Still another facet of cost saving involves statewide efforts coordinated by The Hospital Association of Pennsylvania through its shared services corporation, the

Pennsylvania Hospital Services Association (PHSA). Four areas of PHSA involvement are insurance, computer services, management engineering and biomedical engineering.

In insurance, the Association offers nine programs ranging from workmen's compensation insurance to liability protection for hospital employees and trustees. Annual premiums for these nine programs exceed $15,000,000 - substantially less than participating hospitals would have to pay on an individual basis.

In addition, over fifty Pennsylvania hospitals participate in PHSA's shared computer services program. Services include patient billing, accounts receivable, payroll, cost allocation, medical records, and many others. Participation in such joint efforts eliminates duplication of facilities and services and reduces administrative costs.

Likewise, a number of hospitals are utilizing the services of PHSA's Management Engineering and Cost Control Service, sponsored jointly with the New Jersey Hospital Association. The program provides services in manpower utilization, work and systems analysis, quality control and statistical analysis and cost reduction control. Over 225 engineering projects were completed in Pennsylvania through 1975, with verified savings to the hospitals of over $15,000,000. PHSA's recently established biomedical engineering program offers to institutions scheduled inspections of clinical equipment for safety and performance, training of clinical personnel to use medical devices safely and effectively, and assurance for both hospitals and their patients that the technology on which they both rely is safe, cost-effective, and reliable.

Participation in all of these programs represents good management practice, as do cooperative efforts in education, training, manpower recruit-

ment and regional planning, among others; but they lack the visibility and the dramatic impact on the cost of health care of some of the areas previously mentioned. Nevertheless, the hospitals of the Commonwealth - on their own, as well as through their state and regional associations - are continuing to strive toward maintaining and improving the quality of care they provide to their communities, while trying to keep the cost within the ability of the public to pay for that care.

SUMMARY

Increasing hospital costs have been, and will continue to be, significantly related to the inflationary economy of recent years. The industry's highly-trained professional personnel and wide range of services and supplies sharply reduce its ability to control costs without curtailing necessary community services and/or reducing the quality of patient care. Although hospitals must buy, build and hire in the same market place, they cannot offset costs by increasing production - as can industry, or by levying additional taxes - as can government.

In most cases, the additional costs have been offset by improvements in medical technology and the addition of new services. These have directly contributed to the decreasing average length of stay for hospital patients in the Commonwealth.

In addition, hospitals have taken considerable steps toward minimizing costs in areas under their control. Economies of scale have been obtained largely through the cooperative efforts of many institutions by participation in numerous shared service programs. Also, increased efficiency and better management techniques have been produced through management engineering studies and elaborate management reporting systems.

These cost containment activities will continue and new ones will be developed. However, the industry cannot begin to solve the problems beyond the realm of its own control.

Statistical information at the national and state levels is attached.

February 1977

95-195 O - 77 - pt. 2 - 32

A STATISTICAL LOOK AT COMMUNITY
SHORT-TERM GENERAL HOSPITALS IN PENNSYLVANIA

	1972	1973	1974	1975
Total Hospitals	232	232	239	240
Total Beds	54,092	53,633	55,087	54,907
Total Admissions	1,702,615	1,721,811	1,810,733	1,820,715
Total Inpatient Days	15,452,735	15,260,286	15,694,182	15,462,326
Total Inpatient Day Equivalent*	17,371,224	17,342,186	18,033,752	17,787,851
Total Emergency Visits	3,501,170	3,771,359	4,241,973	4,268,824
Total Outpatient Visits	13,655,547	14,011,261	15,897,416	16,028,180
Total Equivalent Fulltime Personnel**	125,551	126,768	134,180	138,461
Total Payroll Expense	$ 894,431,000	$ 952,855,000	$1,060,481,000	$1,215,094,000
Total Annual Expense	$1,519,708,000	$1,654,256,000	$1,882,072,000	$2,210,611,000
Average Daily Census	42,222	41,882	42,996	42,409
Average Length of Stay	9.1	8.9	8.7	8.5
Average Cost/Inpatient Day Equivalent	$87.48	$95.39	$104.36	$124.28
Average Number Employees/Patient	2.97	3.03	3.12	3.26
Average Salary/Employee	$7,124.05	$7,516.53	$7,903.42	$8,775.71
Occupancy Rate	78.1%	78.1%	78.1%	77.2%
Outpatient Visits - Admissions (Ratio)	8.0/1	8.1/1	8.8/1	8.8/1

* - Total of Outpatient visits adjusted to equal Inpatient days - plus Inpatient days

** - Total of Part-Time Personnel adjusted to equal Full-Time Personnel - plus Full Time Personnel

Source: Hospital Statistics, American Hospital Association, August, 1973, 1974, 1975, 1976.

COMMUNITY - SHORT-TERM GENERAL HOSPITALS:
COMPARISONS BETWEEN STATES

AVERAGE COST PER INPATIENT DAY EQUIVALENT*

	1972	1973	1974	1975
New York	$118.20	$128.32	$140.02	$164.41
Maryland	109.50	120.85	130.44	153.78
Delaware	103.03	109.83	113.15	139.19
New Jersey	88.83	98.97	109.58	125.88
Pennsylvania	87.48	95.39	104.36	124.28

AVERAGE COST PER CASE ADJUSTED*

	1972	1973	1974	1975
New York	$1,134.72	$1,257.54	$1,372.20	$1,627.66
Maryland	919.80	1,003.06	1,093.70	1,276.37
Delaware	834.54	900.61	950.46	1,155.23
New Jersey	781.70	870.94	964.30	1,095.16
Pennsylvania	796.07	848.97	907.93	1,056.38

* - The terms "Equivalent" and "Adjusted" used in the above tables serve the purpose of extracting outpatient utilization and costs to more accurately reflect the actual cost per "inpatient day" and "stay."

Source: Hospital Statistics, American Hospital Association, August, 1973, 1974, 1975, 1976.

COMMUNITY SHORT-TERM GENERAL HOSPITALS

AVERAGE COST PER INPATIENT DAY EQUIVALENT
1974 and 1975

RANK	STATE	COST PER INPATIENT DAY EQUIVALENT 1975	1974 (Rank)	INCREASE 1974 to 1975
1	California	$185.61	$155.78 (2)	$29.83
2	Alaska	183.65	163.04 (1)	20.61
3	District of Columbia	180.31	146.38 (4)	33.93
4	Massachusetts	176.02	152.33 (3)	23.69
5	New York	164.41	140.02 (7)	24.39
6	Connecticut	163.31	141.56 (6)	21.75
7	Rhode Island	161.52	133.41 (8)	27.91
8	Nevada	159.41	142.41 (5)	17.00
9	Maryland	153.78	130.44 (9)	23.34
10	Washington	151.54	125.83 (11)	25.51
11	Arizona	149.99	129.45 (10)	20.54
12	Michigan	144.08	122.46 (12)	21.62
13	Illinois	143.44	121.01 (13)	22.43
14	Oregon	140.68	116.82 (15)	23.86
15	Delaware	139.19	113.15 (17)	26.04
16	Florida	136.85	113.13 (18)	23.72
--	U.S. AVERAGE	133.81	113.55 (16)	20.26
17	Colorado	131.24	111.74 (19)	19.50
18	Hawaii	130.21	118.19 (14)	12.02
19	Utah	126.99	110.27 (20)	16.72
20	New Jersey	125.88	109.58 (21)	16.30
21	New Mexico	124.86	103.23 (24)	21.63
22	Ohio	124.81	107.36 (22)	17.45
23	Louisiana	124.68	103.03 (25)	21.65
24	PENNSYLVANIA	124.28	104.36 (23)	19.92
25	Georgia	121.82	102.57 (26)	19.25
26	Oklahoma	117.80	98.22 (28)	19.58
27	Maine	117.10	96.54 (33)	20.56
28	Texas	116.82	97.17 (32)	19.65
29	Missouri	116.74	97.90 (30)	18.84
30	Vermont	115.32	99.49 (27)	15.83
31	Wisconsin	114.42	98.20 (29)	16.22
32	Indiana	112.19	95.43 (34)	16.76
33	New Hampshire	111.62	95.12 (35)	16.50
33	Minnesota	111.62	97.60 (31)	14.02
35	Virginia	109.25	91.81 (36)	17.44
36	Nebraska	108.16	90.93 (38)	17.23
37	Alabama	105.92	91.58 (37)	14.34
38	Tennessee	104.15	88.88 (39)	15.27
39	Wyoming	103.82	84.55 (46)	19.27
40	Idaho	102.89	88.40 (40)	14.49
41	Kansas	102.49	87.02 (42)	15.47
42	South Carolina	101.75	86.45 (43)	15.30
43	North Carolina	100.97	88.18 (41)	12.79
44	Iowa	99.36	85.52 (44)	13.84
45	Montana	99.28	82.56 (47)	16.72
46	Kentucky	98.33	85.26 (45)	13.07
47	West Virginia	97.06	82.08 (49)	14.98
48	Arkansas	94.57	82.27 (48)	12.30
49	Mississippi	93.62	80.36 (50)	13.26
50	North Dakota	92.88	78.40 (51)	14.48
51	South Dakota	92.01	77.86 (52)	14.15

Source: Hospital Statistics, American Hospital Association, August, 1976

COST PER INPATIENT DAY EQUIVALENT OF THE 25 LARGEST CITIES
(Community Short-Term General Hospitals)

1975

		C/IDE	Population Rank
1.	Boston	$271	(16)
2.	Los Angeles	247	(3)
3.	San Francisco	211	(13)
4.	New York, NY	196	(1)
5.	Seattle	180	(22)
6.	Washington, DC	180	(9)
7.	San Diego	178	(14)
8.	Chicago	178	(2)
9.	Detroit	171	(5)
10.	Baltimore	171	(7)
11.	Philadelphia	164	(4)
12.	Milwaukee	163	(12)
13.	Phoenix	163	(20)
14.	Cleveland	154	(10)
15.	New Orleans	153	(19)
16.	Denver	153	(25)
17.	Indianapolis	152	(11)
18.	Jacksonville	151	(23)
19.	Pittsburgh	141	(24)
20.	Houston	140	(6)
21.	Dallas	132	(8)
22.	Columbus, Ohio	131	(21)
23.	St. Louis	127	(18)
24.	Memphis	125	(17)
25.	San Antonio	123	(15)

Source: Hospital Statistics, American Hospital Association, August, 1973, 197-, 1975, 1976.

Note: Amounts rounded to nearest dollar. Entire Standard Metropolitan Statistical Area (SMSA) figures included for each city.

THE HOSPITAL ASSOCIATION OF PENNSYLVANIA

THE IMPACT OF GOVERNMENT REGULATIONS
ON HOSPITAL COSTS

I. The Variety and Number of State and Federal Agencies Involved in the Regulatory Process for Health Care Demands Reform.

Since 1935, Congress has been passing laws having to do with health, health resources, environmental protection, and biomedical research at an accelerating rate.

The effect of this legislation has vastly increased government regulation of and participation in health and medical affairs. The federal government now finances more than 60% of all biomedical research and development, provides over 40% of the revenue of medical schools and pays about 30% of all medical and hospital charges. It also supports a number of health programs and services directly and in conjunction with the state and local governments.

The Hospital Association of New York State recently completed its "Report of the Task Force on Regulation" which clearly demonstrated that because of the complexity of services and the multiple sources of hospital income, almost every department in a hospital is now subject to government regulation in some form. The New York study demonstrated that a total of 164 different regulatory bodies were currently involved with hospitals in New York State to include: 136 state and federal agencies, 18 city and county agencies, 10 voluntary and quasi-public agencies. The duplication of agency efforts and fragmentation of inspections are alluded to often in the New York report. The study lists seven major principles which would bring some sense of order and reasonableness to the chaotic situation which exists:

1. Promote an end to the fragmentation of health policies at the federal and state levels of government.

2. Consolidate inspections and audits.

3. Coordinate utilization review under PSROs rather than duplicative state on-site reviewers.

4. Establish an objective decision-making body to regulate health facilities.

5. Develop rational standards for audits and surveys.

6. Assure due process in all matters relating to hospital operations.

7. Reduce regulatory lag.

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The Hospital Association of Pennsylvania has recently compiled a 192-page document listing 67 areas of regulatory activity in which hospitals and hospital personnel are legally bound by Pennsylvania law. Its primary purpose is to provide hospital administrators and their key staff members with a comprehensive, yet concise, source of state laws and regulations pertaining to voluntary, nonprofit, general and special hospitals in Pennsylvania. This major study lists 67 state statutes with a myriad of rules and regulations affecting hospitals in Pennsylvania. This is only at the state level and does not include the many federal and local government requirements. The problem of over-regulation, in our view, is so great that it is now time for a considerable effort to be made to revamp the statutory and regulatory requirements placed on the health care industry so that duplication is avoided, administrative costs are decreased, and quality is not jeopardized.

The problems we are emphasizing under this section apply to virtually all hospitals in all states. The present situation is indeed chaotic and should be addressed at both the national and state level. Recent legislation in Kentucky to create an act relating to inspections is attracting national attention. This act requires that effective July 1, 1978, no inspecting agency in Kentucky shall conduct an inspection that duplicates an inspection conducted by another inspecting agency or by the federal government.

Literally hundreds of examples could be given to further demonstrate the problem, but we think the point is made. The key is that reform of federal and state regulatory practices is a major problem affecting the health industry which demands corrective action at the federal and state level.

II. Surveys and Data Collection Must be Coordinated.

In February, 1975, our Association initiated a study designed to bring into focus the number and types of surveys that our hospitals were being asked to complete each year. In addition, it was hoped that the time and personnel required to complete surveys could be identified.

Eleven hospitals representing all bed sizes, forms of ownership, and geographic areas of the state agreed to compile information on each survey received for a one-year period.

Findings

A. Number of surveys - total -

Between the sample group members, 748 surveys were received. All of the eleven hospitals reported receiving surveys that none of the others received and conversely all of the eleven reported receiving surveys that all of the others received. After reviewing all of the "surveys received" we found that 335 different surveys were received by the eleven hospitals during one year

B. Number of surveys per hospital -

The sample group reported an average of 68 surveys received per year.

On the average, these hospitals completed 58 surveys (85%) per year -- about five of the six they receive each month.

Time Required to Complete Surveys

The overall average time to complete a survey regardless of the type or source of the survey was 3 hours, 40 minutes.

Based on the average time per survey, each hospital spent an average of 212 hours, 40 minutes or 47 man-days or more than 5 man-weeks completing surveys last year.

Conclusions

A. If we assume that all Pennsylvania community hospitals (of which there are 239) received the average number of surveys (68) that the sample group received and completed the average number of surveys that the sample group completed, the following amount of time would have been spent in completing surveys in 1975.

In total man-hours - 50,800

In total man-days - 6,350

In total man-weeks - 1,270

In total man-years - 24.4

B. Further, if we assume that the average salary for hospital employees lending time to complete these surveys was $10,000 per year, the cost for complying with data requests in 1975 was approximately 1/4 million dollars or approximately $1,000 per hospital.

Observers of survey efforts in the health field are convinced that the number of requests for data made of hospitals is increasing. Our specific goals in Pennsylvania are:

1. To create a system and procedure designed to screen and eliminate unnecessary voluntary questionnaires directed to hospitals in Pennsylvania prior to distribution to hospitals for completion.

2. To organize and implement a commission concept whereby recognized data collectors pool resources and share the products of data undertakings. Under this concept state government, third party payers, and voluntary agencies would vest the authority and support in a recognized data collection center designed to collect what is needed and provide appropriate information to all participants.

Under Public Law 92-603, an amendment to the Social Security Act, utilization review activities must be coordinated with PSROs serving as the primary utilization review agencies. The entire utilization review area is clouded with duplication and uncertainty. In Pennsylvania, all hospitals currently participating in the Medicaid program are required to send duplicate information to the local PSRO and the state Medicaid department. Not only is this a costly duplication of data collection, but the Department of Public Welfare continues to employ a large number of state employees who are duplicating the activities of the people employed by the local PSROs. In a September 3, 1976 transmittal, the Social and Rehabilitation Service clarified a number of current issues with respect to the relationship of PSRO review responsibilities to Medicaid and made the following points:

1. States no longer have to make satisfactory showing of effective utilization review and facilities where a PSRO has assumed the review responsibility. In addition, states are no longer subject to financial penalties related to meeting requirements for physician certification and recertification, physician plan of care in short-stay hospitals, and UR in PSRO-covered facilities.

2. Federal financial participation will not be available for the costs of a state review or monitoring system which duplicates the purposes of PSRO review.

3. Federal financial participation is not available where a state pays a claim for services disapproved by a PSRO as not medically necessary or appropriate.

4. If a PSRO approves service as medically necessary and appropriate, but the state denies payment on the grounds of lack of medical necessity, a question of substantial compliance with the state plan would arise. Financial penalties might then be imposed on states found substantially out of compliance with the state plan after an HEW hearing on the issue.

These guidelines are being ignored by Pennsylvania and most other states, and the result is needless and costly duplication.

III. Government Regulations Which Increase Hospital Costs

In June, 1976, the Ohio Hospital Association completed a major study on federal, state, and voluntary controls to identify: name or source of control; who and what does it affect; what does it do; how does it control; by whom is it controlled. This relatively simple, yet comprehensive, document clearly demonstrates the types and variety of controls currently in use in the health industry. Every item listed from on-site inspections, surveys, data collection, to audits has a price tag, and that price tag is growing dramatically.

Strict enforcement by state and federal regulatory bodies of the Life Safety Codes of 1967 and 1973 will cost Pennsylvania hospitals more than $400 million. The Hospital Association of Pennsylvania has developed eleven specific programs to try to modify, where appropriate, strict enforcement. Compliance with other regulations (e.g. Pennsylvania Health Department's proposed licensing regulations, OSHA, etc.) likewise results in increased costs.

The State's poor record of management in the Medical Assistance program is another example of how government regulations impact on hospital costs. Significant problems in reimbursement, claims processing, eligibility determination and a host of other areas finally led over 180 Pennsylvania hospitals, in 1976, to authorize The Hospital Association of Pennsylvania to negotiate a new contract with the Commonwealth in their behalf. Although some of the problems have been alleviated under the renegotiated inpatient agreement, serious problems -- particularly with regard to under-reimbursement -- remain in the outpatient area. Put most simply, paying patients are forced to subsidize Medical Assistance beneficiaries' outpatient care because of the inadequate, arbitrary fee schedules used by the Commonwealth of Pennsylvania.

IV. Hill-Burton Charity Requirements

Hospitals, long term care, outpaitent and rehabilitation facilities, and public health centers which have acceoted grants or loan applications under Title VI of the Public Health Service Act are required to provide a reasonable volume of service to persons unable to pay for care. The obligation lasts for twenty years after the facility using a Hill-Burton grant was opened. The obligation lasts for the length of time that the loan guarantee, interest subsidy, or direct loan is in effect for those facilities which have participated in these programs.

Federal regulations give the Pennsylvania Department of Health three major areas of responsibility:

1. Determination for each applicant of the level of uncompensated services which constitutes a reasonable volume of services to persons unable to pay.

2. Developing criteria for identifying persons unable to pay as a basis for determining the amount of qualifying uncompensated services provided by an applicant.

3. Annual evaluation of the amount of uncompensated services provided by each aided facility to determine whether it is in compliance with its assurance, investigation of complaints, remedial action to enforce the assurance in instances where the applicant is found not to be in compliance.

Pennsylvania requires hospitals to demonstrate that they are providing a

reasonable volume of service under one of the three options chosen by the hospital:

1. A hospital may advise the state that it does not intend to deny anyone admission to the hospital or any of its services because of inability to pay (open door policy).

2. It may advise that its level of uncompensated care for persons unable to pay will be equal to 10% annually of the sum of all Hill-Burton grants received within the past twenty years.

3. It may advise that the proposed level of uncompensated care will be equal to the sum obtained by subtracting Medicare and Medicaid reimbursement from the hospital's operating cost and then taking 3% of the remainder.

The requirement of hospitals to provide charity care has a substantial impact on the operating cost of the major urban hospitals in Pennsylvania and in some cases undermines the entire financial structure of a hospital. If all Pennsylvania hospitals selected option #2, for example, we estimate that they have a potential responsibility for providing 32 million dollars per year in charity care.

V. Planning

The Social Security Amendments of 1972 (P.L. 92-603) and the National Health Planning, Resources and Development Act of 1974 (P.L. 93-641) reflect the desire of the federal government to control or contain hospital expenditures for construction, renovation, services, and capital equipment through mandated planning.

Institutional Planning

Section 234 of Public Law 92-603 requires as a condition of participation under the Medicare program, that hospitals develop a written plan reflecting an annual operating budget and at least a three-year projected capital expenditures plan. This operating budget must be updated annually to project all anticipated income and expenses. The capital expenditures plan must include specific details on any anticipated capital expenditure in excess of $100,000, showing both the source of the proposed financing and the objectives of each expenditure.

The 1122 Review Program

Section 221 of Public Law 92-603 authorizes the Secretary of the Department of Health, Education and Welfare to withhold or reduce reimbursement amounts under Titles XVIII, XIX and V—after consultation with approved planning agencies—to hospitals for depreciation, interest, and in the case of proprietary hospitals a return on capital equity, related to capital expenditures that are determined to be inconsistent with state or local

health facility plans. This Section defines capital expenditures to include:

1. Plant and equipment in excess of $100,000
2. Any increase or decrease in bed capacity of the hospital
3. Substantial changes in services provided by the hospital

The National Health Planning, Resources and Development Act of 1974

This Public Law was enacted to replace and to strengthen the Comprehensive Health Planning Program, the Regional Medical Programs, and the Hill-Burton Program. It seeks to establish at the federal, state, and the local or regional level an interrelated system through which health planning, regulation, and allocation of resources will be conducted throughout the nation. Under this Act, a series of health systems agencies (HSA) are created to form a national network of local planning agenices, each of which must have a governing body that includes a majority of consumers. Included among the activities of HSAs will be the development of long-range health systems plans and short-range implementation plans; review and approval or disapproval of applications for federal funds from area health programs; assisting states with capital expenditure reviews; assisting states in making determinations concerning the need for new institutional health services and the appropriateness of existing health services; and generally planning for improvement of the quality, availability and accessibility of health care services while trying to contain cost increases.

The law requires that all health institutional services in a state be reviewed for appropriateness at least every five years (recertification of need) and that the results of the reviews be made public. In addition to recertification, the law requires that all states have certificate of need legislation under which services and facilities cannot be added without planning agency approval (HSA).

Finally, the law requires development of a national accounting system to monitor the volume and cost of health care services.

The health planning legislation will increase hospital operating costs. To survive, a hospital must substantially increase its planning capability in terms of additional employees as well as collection, analysis, and utilization of institutional planning statistics in order to justify appropriate expenditures that are governed by this legislation. Hospitals have publicly supported the adoption of the Act and are striving to implement it. Past experience, however, would indicate that this legislation will produce a large bureaucracy, totally dedicated to requiring new and highly-detailed financial and statistical reports, administrative delays and a substantial increase in operating frustration for hospitals.

EXAMPLES OF LEGISLATION WHICH HAVE A MAJOR IMPACT ON INCREASING HOSPITAL OPERATING COSTS

1. Fair Labor Standards Act - The health care industry's exemption under this act was repealed by Congress in 1967. This Act requires hospitals to pay a minimum hourly wage to covered employees. The minimum wage has risen from $1.90 per hour on May 2, 1974 to $2.30 per hour on January 1, 1977. In addition, hospital employees must be paid at the rate of time and one half the basic hourly rate for all hours worked in excess of forty hours in a single work week. This statute has signigicantly increased the direct salary costs for certain categories of personnel employed by hospitals.

2. The National Labor Relations Act - In July, 1974, Congress repealed the hospital exemption of the Taft-Hartley Act making the law's terms and the jurisdiction of the National Labor Relations Board applicable to non-profit hospitals. The law directs the National Labor Relations Board to perform two principal functions: to investigate and adjudicate unfair labor practices committed by employers and unions, and to conduct secret ballot elections among employees. Inclusion of hospital employees under this statute has stimulated considerable union activity in the hospital industry. This has been a major factor in forcing hospitals to increase employee wage and fringe benefit packages in both unionized and non-unionized hospitals.

3. Equal Employment Opportunity Laws - These laws, which include Title VII of the Civil Rights Act of 1964, the Equal Pay Act of 1963, the Age Discrimination and Employment Act, Section 304 (A) of the Consumer Credit Protection Act, the Vietnam Era Veterans Readjustment Assistance Act, Executive Order 11246, Executive Order 11375, Executive Order 11141, and Section 503 and 504 of the Vocational Rehabilitation Act of 1973, forbid employment discrimination in differing respects. The effects of these statutes and the regulations and rulings of the Equal Employment Opportunity Commission have forced hospitals to modify existing record systems, acquire personnel to implement and maintain the additional paperwork, develop training programs and initiate recruitment efforts.

4. Federal Unemployment Compensation Amendments of 1970 - These amendments required states to change their unemployment compensation statutes to provide for the coverage of hospital employees. Although hospitals were given the option of paying for employee benefits on a reimbursement of cost basis, hospital unemployment compensation costs have soared because of the escalating expansion of benefit payments and the extension of benefit periods. Increased costs are also reflected in preparing adequately to contest and dispute claims and in pursuing appropriate hearing and appeals procedures.

5. Employment Retirement Income Security Act of 1974 - This statute, more commonly referred to as the Pension Reform Act, mandates many pension plan requirements, including increased participation and vesting, which can have a major impact on the cost to the employer of maintaining pension plans currently in effect. The Act provides for expanded reporting and funding requirements and stiff penalties to both employers and fiduciaries for failure to live up to its provisions. This legislation has substantially increased fringe benefit costs for hospital personnel.

6. Occupational Safety and Health Act of 1970 - This law was enacted "to assure every working man and woman in the nation safe and healthful working conditions". All employers are required to provide employment conditions that are free from hazards which might cause death or serious physical harm and to comply with the safety and health standards promulgated under the Act. The OSHA standards persently cover hundreds of pages of printed matter, encompassing thousands of detailed matters. These standards include, but are not limited to the following: housekeeping; aisles and passageways; floor loading protection; means of egress; fire protection; sanitation; electrical requirements; protective equipment for personnel; accident prevention; signs and tags; and laundry machinery and operations. The cost of complying with these standards and maintaining the proper records and documentation to monitor compliance imposes a major additional expense on hospitals.

7. Life Safety Code Requirements - Federal regulations issued under Title XVIII and Title XIX of the Social Security Act require all hospitals to be in compliance with the 1967 Life Safety Code as a condition for participation in the Medicare program. However, hospitals receiving grants or loans under the Hill-Burton Act must comply with the 1973 Life Safety Code. Hospitals maintaining a skilled nursing facility must be in compliance with the 1973 Life Safety Code for the skilled nursing facility to be approved for participation in the Medicare program. Finally, hospitals must also comply with a wide variety of differing state and local fire and safety codes to be in compliance with state and local statutes. Conservative estimates in Pennsylvania indicate that $400 million is required to bring hospitals into compliance with the 1967 and 1973 Life Safety Codes.

8. Professional Standards Review Organizations - P.L 92-603 Section 249 F The main thrust of PSROs and utilization review is to determine whether or not the level and quality of health care being provided is appropriate. The primary emphasis of this legislation is to reduce the length of stay in acute care hospitals. However, the results of reducing length of stay have often been a cause of increasing hospital costs. Shortening the length of stay has necessitated a greater intensity of service in less time. This increases the hospital's unit cost considerably. In addition, hospitals must now employ utilization review coordinators to implement these programs at the hospital level. Finally, there are other costs related to paperwork requirements and administrative expenses for staffing local PSROs. Public Law 92-603

has accomplished a major goal of reducing the patients' length of stay but in that same process has directly increased hospital operating costs.

9. Medicare Regulations - This major legislation has increased hospital operating costs in many ways, and literally hundreds of examples could be given but for the purpose of this paper we will simply cite three:

A. Medicare regulations concerning depreciation (20 CFR.401. 415). Contrary to the Government's intent, this Section of the Medicare regulations which allows only straight line depreciation for capital investments is increasing, rather than containing, hospital costs. This policy forces hospitals to borrow for longer periods of time, thus increasing the institutions' total interest costs and the tax dollars needed to finance Medicare reimbursement. Therefore, Medicare's requirement that hospitals employ a straight line depreciation method does not affect the overall reimbursement but does delay amortization of debt and increases interest charges.

B. Limitations on payment or reimbursement for drugs (40 FR 32284). The maximum allowable cost regulation establishes a mechanism to limit reimbursement or payment for prescribed drugs furnished under federally-subsidized health care programs. Medicare reimbursement is limited to the lowest of: 1) the maximum allowable cost of the drug if any (as determined by the Pharmaceutical Reimbursement Review Board) plus a reasonable dispensing fee; 2) the acquisition cost of the drug plus a reasonable dispensing fee; or 3) the provider's usual and customary charge to the public. These regulations have created an entirely new bureaucratic structure (Pharmaceutical Reimbursement Review Board) to supervise and advise FDA on the implementation of these regualtions. Additional expense is incurred by institutions for record-keeping. Another cost problem exists for smaller institutions, since the maximum allowable cost is based on purchase of drugs in quantities which these hospitals may find to be impractical; hence, their unit costs will be higher.

C. Medicare regulations concerning reimbursement for capitalization of captive malpractice insurance companies - the malpractice crisis has seriously limited the number of insurance companies willing to provide professional liability coverage for hospitals and other health care providers. To cope with this problem, many hospitals have sought to either self-insure or to collectively form through their state hospital associations, captive insurance companies to provide malpractice insurance, as has been done in Pennsylvania. These mechanisms have principally been encouraged as a vehicle for maintaining the availability of insurance at competitive rates. The Bureau of Health Insurance has reacted to this positive approach by stating that it is unwilling to recognize the money spent to capitalize the insurance company or create self-insurance reserve funds as allowable costs for Medicare reimbursement. This decision is currently being appealed - appeals also add additional costs to the industry.

10. Pennsylvania Mental Health Procedures Act (Act 143) of 1976 - The Pennsylvania Mental Health Procedures Act of 1976 and the regulations thereto will significantly increase the cost of providing psychiatric services in Pennsylvania. Requirements for reporting both voluntary and involuntary admissions to County Mental Health/Mental Retardation administrators within strict time limits imposes the necessity for increased numbers of hospital personnel to handle the extensive paperwork required (including the availability of a 24-hour per day notary). Further, time "costs" of physicians and other professionals will also result from their increased involvement in the hearing process necessary for treatment extensions - to say nothing of legal costs for such hearings. In rural areas with multi-county MH/MR offices, hospital employee travel time is extensive to carry the numerous forms to county administrators within the absolute time limits. Institutions are even being required to duplicate the necessary governmental forms at their own expense. Numerous community mental health centers in the State are struggling for survival as economic resources for their support are reduced. The imposition of increased multiple forms, professional time constraints, clerical demands and legal procedures can only add to an already stressful situation.

11. Proposed Hospital Licensing Regulations in Pennsylvania - The Department of Health recently published a 200-page document on proposed hospital licensing regulations for Pennsylvania hospitals. The cost of implementing these regulations, if adopted, will be substantial for every hospital in Pennsylvania. These regulations call for hospital inspections, increased reporting requirements in every phase of the hospital operation, and increased legal expenses for the health care industry, because the proposed regulations exceed the authority of the State and force hospitals to respond by initiating legal action.

SUMMARY

We have cited a number of examples of legislation which has major impact on hospital operating costs. Obviously, many others could be cited. The purpose of this paper is not to argue the merits of the legislation but to try to emphasize that this kind of legislation increases hospital operating costs. Hospitals are continually caught in the middle. Everyone seems to be saying that hospital costs are rising too fast and must be contained or held to a rate consistent with general inflation in our economy, yet the industry is deluged with regulations that mandate increased costs. Rising hospital costs are a national issue. The industry is taking a number of steps to try to effectively deal with cost containment, but without major regulatory reform these efforts will prove to be an exercise in futility.

SUMMARY OF RECOMMENDATIONS

I. The variety and number of state and federal agencies involved in the regulatory process for health care demands reform.

1. The Federal government should move expeditiously to develop a national health policy to be administered in a more systematic and reasonable fashion through a reorganization and consolidation of activities. This could be accomplished through the creation of a cabinet level department of health as the administrative agency to coordinate all Federal health programs.

2. The Federal Department of Health, Education and Welfare should review the policies and procedures of the twenty-five separate units within that Department that affect hospitals and require coordination of activities to eliminate the prevalent fragmentation and duplication in hospital regulation.

3. Inspections and audits by federal and state agencies should be consolidated and conducted during one annual visit to each health care institution.

4. All utilization review activities for health care institutions should be coordinated under Public Law 92-603 (Professional Standard Review Organizations) rather than duplicative state reviews.

5. Public Law 93-641, the National Health Planning, Resources and Development Act should be properly funded and serve as the primary mechanism for implementing health planning.

II. Surveys and data collection must be coordinated.

1. A system should be created in each state and procedures designed to screen and eliminate unnecessary voluntary and governmental questionnaires directed to hospitals prior to distribution for completion.

2. Each state should organize and implement a commission concept whereby recognized data collectors pool resources and share the products of data undertakings. Under this concept, state government, third party payors, and voluntary agencies would vest the authority and support in a recognized data collection center designed to collect what is needed and provide appropriate information to all participants.

95-195 O - 77 - pt. 2 - 33

III. Many government regulations increase operating costs and run contrary to legislative intent.

1. Legislation should be enacted giving the Congress veto power over executive regulations which exceed legislative intent.

2. All regulations mandated by state and federal government should include an economic statement from the agency issuing the regulations stating how much money implementation of the regulations would cost and how the state or federal program expects these costs to be reimbursed. At appropriate intervals, the actual economic impact should be evaluated and announced.

3. All state regulations should be subject to regular review to assure continued relevancy and to confirm that the need for the regulations still exists.

4. Regulatory lag should be eliminated through careful planning and implementation of legislation rather than last-minute development of regulations or, even worse, retroactive application of regulations developed in haste after the effective date of legislation. When regulations are promulgated, they should be complete and not presented with a series of amendments and corrections.

IV. The health industry must be assured due process with regard to government regulations.

1. Due process must be recognized as a component of all state regulatory operations. Rule-making should include:

(a) Prior notice with adequate time for all interested parties to comment before implementation, preferably at a public hearing.

(b) Fair opportunity for administrative appeals to be heard when adverse decisions are made against hospitals and other providers.

(c) Publication of proposed rules, comments, hearings, decisions and other matters of general interest including the list of hearing officers. When an adverse decision has been rendered there should be specific reasons for the decision, full disclosure of the appeal mechanism, a timely hearing schedule, proper conduct of the hearing and the findings should be made known within a reasonable amount of time.

V. Reasonable costs should be determined prospectively under regulations and operating practices that require Medicare, Medicaid, and Blue Cross to use the same definitions in determining reasonable cost.

1. The reasonable cost concept currently lets government define what is reasonable according to its standards and without a legislative check or judicial review. This power has been abused by government particularly in recent years when the budget has been under extreme pressure. Often the government has restricted reimbursement not because the cost of the service was unreasonable as a financial matter but because the government was seeking ways to reduce federal expenditures for health care. Thus, the government has transformed a system that was intended to prevent hospitals from overcharging into a mechanism for underpaying them. An effective health care system cannot be operated under the gun of self-serving decisions by the government. Any purchaser of services, and that includes the government, should not be able to buy what it wants and then, unilaterally, after the services are delivered, determine what it deems sufficient compensation.

Hospital Affiliates International, Inc.

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Nashville, Tennessee 37205
Telex 554309

July 5, 1977

Stuart Shapiro, M.D.
Subcommittee on Health and Scientific Research
Committee on Human Resources
United States Senate
Washington, D.C. 20510

Dear Dr. Shapiro:

We have followed the progress of the Administration's Hospital Cost Containment Act with deep concern. In the interest of maintaining an effective and quality oriented health care system, we submit the enclosed statement of observations gleaned from our experience in operating 80 hospitals over a period of several years. The majority of the hospitals we operate are nonprofit acute general hospitals owned by cities, counties, medical schools and various voluntary groups.

As one of the largest operators of hospitals in the nation, we are pleased to share the knowledge we have gained with the United States Senate.

Very truly yours,

Jack R. Anderson
Chairman

JRA:ms

cc: Senator Howard H. Baker, Jr.
Senator James R. Sasser

STATEMENT FOR THE RECORD SUBMITTED BY

JACK R. ANDERSON, CHAIRMAN

HOSPITAL AFFILIATES INTERNATIONAL, INC.

TO THE

SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH

COMMITTEE ON HUMAN RESOURCES

UNITED STATES SENATE

WASHINGTON, D.C. 20510

Hospital Affiliates International is a national hospital management company which has 80 hospitals in operation or under development with more than 11,000 beds. The company provides management services to university teaching, county, municipal, district, foundation, investor-owned, and other community non-profit hospitals. Most of the institutions under Hospital Affiliates management are in the non-profit sector.

We support the cost containment objectives of the Congress and Administration. However, the proposal advanced by the Administration has a number of short comings which could result in serious impairments in patient care. Stringent regulation by government often produces as a by-product, reductions in quantity or quality of the goods or services regulated. In the case of the Hospital Cost Containment bill proposed by the Administration, decreases in the quantity and quality of patient care can be expected to occur.

A limitation on hospital income without a compensating decrease in patient volume will require proportionate reductions in expense. This would result in decreases in personnel and supplies which can only have an adverse impact on the clinical care of patients. Certain services would have to be curtailed. The hospital, as a provider of services ordered by physicians, is poorly suited to deciding which services should be offered and which can be withheld.

Another shortcoming is the proposed uniformity in applying the limitation in hospital payments. Under the Administration's proposal an efficient hospital operating at a cost of $100 per patient day would receive perhaps a $9 increase in revenue. At the same time an inefficient hospital with a cost of $200 per patient day would receive an increase twice as large. Further, there is the potential for this ceiling to become a floor if concern for the future causes hospitals to take the present maximum allowable revenue increase regardless of need.

The growth of technology in hospitals can be expected to decline under the Administration proposal. This may be appropriate for the large sophisticated institutions, but it would adversely effect the smaller suburban and rural hospitals where a technological deficit exists. Measured improvements in the technological resources of these hospitals could have the effect of reducing the necessity for referrals to the large, higher cost institutions.

Finally, the basic thrust of the Administration's bill is directed at the symptoms rather than the causes of the high rate in increase in payments to hospitals. It is the nature of the payment system that forms the foundation of this problem and therefore, it is upon this area that the remedies should be applied.

It is estimated that by 1978 only 8.3% of the nation's hospital bill will be paid out-of-pocket by consumers. Since nearly all hospital care is paid for by prepayment or governmental programs, the incentive to restrain demand for services is not strong. The patient makes his decision about the purchase of hospital care based primarily on the advice of his doctor. Since he considers his care to have been paid for in advance, its cost is not a significant factor in his decision. The doctor is concerned primarily with the patient's recovery in his decisions. Cost is a factor to him only to the extent that he seeks to be assured that the bills will be paid and that the cost is not a burden to the patient. Third party payors are interested in cost only in its relation to projected sources of payment. They seek assurance that the premium structure or budget is adequate to cover the cost of the services the patient receives.

In other sectors of our economy, consumer demand is restrained by cost. However, in the health care industry the popularity of insurance with low deductibles and minimum co-insurance has dislocated these forces. The result is the increasing patient volume and, more importantly, the increasing quantity and sophistication of the care each patient receives.

Since insurance premiums are not taxable, there is a tendency for insurance benefits to include complete coverage. A change in public policy limiting this favorable tax treatment to the cost of coverage for expenditures beyond the level of routine care could cause the consumer to become a more prudent buyer of health services. The dollar spent on health care would then be on an equal level with the dollars spent on other items. This could be expected to result in it being spent on non-health items to some degree, thereby reducing the demand for health services. Such a policy shift should, however, continue to recognize the social value of favorable tax treatment as a form of subsidy for premiums related to coverage for higher cost care that the patient could not be expected to afford out-of-pocket. The result would be a trend toward a pattern of high deductibles and graduated co-payments at the higher levels.

Reductions in health expenditures would also result from the development of provider incentives. The establishment of methods of rewarding the efficient and penalizing the inefficient would, in the long run, further reduce the rate of increase of payments to hospitals.

The strengthening of a number of positive elements already at work in the health industry would further restrain expenditures. Congress has enacted legislation to create systems at the local level for the planning and coordination of investment in facilities and equipment which will keep the hospital services of each community in step with that community's needs. These Health Systems Agencies are now just beginning to operate and we are confident that this problem is well on its way to being solved. The enactment of Professional Standards Review Organization program is a remedy which is, likewise, in the early stages of operation. It has great promise for controlling utilization. We feel, therefore, that this also is an aspect of the problem which is well on its way to being solved. Most of our nation's hospitals are governed by voluntary boards of trustees. These men and women understand the needs and desires of their communities. They are dedicated to the quality of care, as well as economical operation.

The three foregoing elements deserve the continued support of Congress. As key elements of our health care system, they should be strengthened as the health policy of the future takes shape.

In summary, we support the hospital cost containment goals of Congress and offer our assistance in developing methods of achieving improved cost effectiveness. The causes of the rapid rise in hospital care expenditures are varied and complex. However, Congress has already set programs into motion which will bring about improvements in the expenditure area as evidenced by the recent down-turn in the rate of increase. We urge the development of an incentive oriented cost containment system and its application to hospitals according to type and size. We urge Congress also to apply its resources to a study of the payment system for health care and the development of incentives that give patients and providers a financial interest in efficiency and restrained demand.

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Hospital Financial Management Association

Ronald R. Kovener, FHFMA, Associate Executive Director

June 21, 1977

DEAR SENATOR:

The Hospital Financial Management Association has concerns about the proposed Hospital Cost Containment Act of 1977 (S. 1391) as described in the attached statement. Because of the misconceptions about the bill and its inequities, complexities, deficiencies and dangers, we urge you to vote against it.

Many of our members, your constituents, have probably written to you expressing their concerns. Our staff in Washington will be happy to answer your questions about points raised in our statement or raised in other letters you have received.

We urge your careful consideration of the complexities of this bill because we are confident that, once you consider the details, you will agree that the bill will not accomplish its stated objective.

Very truly yours,

Joe McCue

Joseph P. McCue, CPA, FHFMA
President

JPMcC/dc
Enclosure

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Hospital Financial Management Association

Ronald R. Kovener, FHFMA, Associate Executive Director

STATEMENT OF THE HOSPITAL FINANCIAL MANAGEMENT ASSOCIATION

on

S. 1391

THE HOSPITAL COST CONTAINMENT ACT OF 1977
TO THE SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH
OF
THE COMMITTEE ON HUMAN RESOURCES

June 21, 1977

The Hospital Financial Management Association is a professional membership organization representing more than 15,000 individuals who hold financial management positions in hospitals and allied health care institutions or who are directly involved in organizations related to health care financial management. These are individuals who will be responsible for the institutional financial planning necessary to comply with this legislation and to file whatever forms are necessary to demonstrate compliance.

We would like to express and briefly illustrate our concerns about the misconceptions concerning S. 1391 and its inequities, complexities, deficiencies and dangers. Due to these concerns we recommend that this bill not be approved.

MISCONCEPTIONS

- A limit of 9% is widely discussed. This is not the limit for several reasons. First, the limit is really a 2 year limit of 1978 over 1976. The actual limit varies depending on the hospital's fiscal year but the most commonly discussed example is a 10/1-9/30 fiscal year for which a maximum of 15% is allowed for 1977 and 9% is added for 1978 for a total of 24% increase. With 1977 as the base the first control year increase limit is not 9% but only 7.8% (124% ÷ 115% = 107.8%). The effect of using addition rather than multiplication results in even greater differences in later years. Second, the limit is further decreased by normal, necessary increases in admissions. National averages in increased admissions in recent years have been around 3%. If a hospital could hold increases in admissions to as low as 1%, the first control year over the prior year (10/1-9/30 FY) limit is not 9% but 4.6% (124% volume adjusted for 2% = 121.6%; 115% x 101% = 116.2%, 121.6% ÷ 116.2% = 104.6%).

- The bill has been represented to be simple for hospitals to administer. It has, for example, been asserted that the calculations are simple - starting with inpatient cost per admission as shown on the Medicare cost report. The fact is that inpatient cost per admission is not shown on the Medicare report. Even to find inpatient cost it is necessary to add together several different numbers from the Medicare report and calculate other amounts not included on the report. The number of items and their location on the forms vary from institution to institution, depending on its circumstances. The calculations necessary for the wage adjustment are so complex as to effectively nullify the provision. HFMA has prepared a case example of the simplest method to planning under these rules that it could devise. The very complex volume adjustments were reduced to a simple table (a step which even HEW staff has not done due to the complexity of the calculations). This material is available on request from HFMA's Washington office.

INEQUITIES

- The program tends to penalize those institutions that have been the best managed and reward those who have been least effective in controlling costs in the past. It makes most vulnerable to penalty those who have tried the hardest.
- The program fails to recognize the individuality of institutions ignoring variations in length of stay (which commonly varies from 4 to 12 days per admission), intensity of services, differences in program, ownership and other factors. Also, the application of a single national rate to all localities ignores significant differences of regions and communities.
- The basis of the national limitation on rate of change does not adequately reflect the goods and services purchased by hospitals which must be reflected in hospital prices. This is an industry that is particularly labor and energy intensive and has many important cost considerations different from those inherent in the measurements on which the proposed national control rate is based.
- The provisions for wages of non-supervisory personnel may create inequities in proper wage differential between supervisory and non-supervisory personnel. This may be very detrimental to retaining appropriate supervisory and professional skills within the industry.
- Notwithstanding assertions to the contrary, this program is being applied retroactively. Most hospitals in the U.S. are already under these controls if it is implemented according to the schedule in the proposed legislation. These hospitals are unable to plan for compliance or to measure compliance. For example, a calendar year hospital could find on enactment of the program that it was 1% over the limits for the first 9 months of its fiscal year. To comply it would have to be 3% under the limits for its last three months thereby requiring a 4% reduction in costs virtually overnight. Even the most competent management could not comply. The great confusion in the bill will probably prevent any determination of compliance until long after the period for which compliance is measured.

- The program fails to give appropriate recognition to governmentally mandated construction programs such as construction required to accommodate the disabled,construction required to comply with Occupational Safety and Health Administration requirements,hiring of additional skilled personnel to meet licensure requirements, changes in minimum wages or changes in governmentally prescribed employee benefits.
- The program fails to give recognition to influences on cost that are beyond the control of the hospital. For example, hospital demand is controlled largely by physicians and not by hospital management. Much of the care ordered by physicians is responsive to other external influences (such as services required to avoid allegations of malpractice).
- Congress recognized the inequity of cost controls applied to a single industry several years ago when the economic stabilization program was discontinued. This proposed program would be no less inequitable.

COMPLEXITIES

- Certain claims made by the Dept. of Health, Education and Welfare in their "Bill in Brief" illustrate its complexities. It is alleged that the bill can be readily understood however its complexity is illustrated by the discovery that the position of a comma made a significant difference in the understanding of a section. Attempts to explain the details of the bill have revealed to HEW staff the significant potential for misunderstanding. These misunderstandings have caused many inquiries to HEW and HFMA to clarify the confusion. The assertion that no new data or new forms are needed is blatantly false as anyone at HEW will now undoubtedly admit. The complexities of the bill are further illustrated by the fact that an example included in the HEW "Bill in Brief" is inaccurate. Even HEW staff was unable to provide a simple example because of the great complexities of the bill. The assertion that each intermediary could settle independently is also in error. Each intermediary will have to make settlement on the basis of institution-wide data which will have to be verified and confirmed by some central authority or there will be significant duplication of effort as each intermediary attempts to make verifications independently.
- Administration of the bill separately for each major payor adds significantly to the complexity, both in identifying who these separate payors are and knowing whether an admission that is sponsored by more than one payor is counted with one group or the other.
- There are many extremely important terms that have not been defined. For example, the phrase in section 102(b) "total revenue...received" is in conflict with the term "charges imposed" in the same section, the former indicating amounts determined on a cash basis, the latter indicating amounts determined on an accrual basis.

- Separate administration for each cost based payor adds to the complexity. An attempt to adjust cost to assure compliance for one cost payor will in turn have an influence on the cost to be reimbursed by all other cost payors. The interrelationship of the various formulas has indicated that unintended results may occur from appropriately intentioned efforts and that computer assistance will undoubtedly be required to plan and monitor compliance.
- The bill introduces the concept of maintaining the institution's share of charity service in the community. This is a concept not previously introduced by any legislation and does not recognize the variations in charity services and does not include appropriate definitions.

HFMA's case example may help in evaluating the complexities of the bill.

DEFICIENCIES

- Notwithstanding its title, the program does not really focus on cost containment. Rather it will encourage hospitals to pay first attention to shifting patients from inpatient to outpatient or to another institution (there is little advantage to shortening length of stay for inpatients), to reduce services and to implement new pricing strategies. A prudent hospital financial manager will give a lower priority to curtailing costs.
- There are very few incentives for compliance with provisions of the program - only penalties.
- The details of the bill do not support the contention that wage changes of non-supervisory employees will not be adversely affected. The bill actually will encourage a decrease of employment and will not permit conscientious management to make wage change adjustments consistent with expectations of labor. An incorrect impression has also been created that these federal limitations would override state limitations which in many cases are lower.
- The program discourages consolidation of services in a community. For example, if hospitals in a community agree to consolidate OB services from several hospitals, the hospital that would receive additional patients as a result of the consolidation would be penalized.
- Hospitals in states that receive an exemption would be much more severely penalized than if the state were not awarded an exemption thereby seriously undermining state rate control programs in place or under development. The program may make hospitals resist such developments in the future. A major deficiency is the fact that volume and wage adjustments normally available will not be available if the state has been granted an exception. The program is generally not compatible with existing state programs and may run contrary to efforts of established state control programs.

DANGERS

- The limitation on charge increases will be the minimum amount which a hospital can prudently increase their charges.
- Exemption criteria are so severe as to undermine the fiscal viability of the industry. Short term interest rates for necessary borrowing by hospitals will undoubtedly be increased and necessary long term borrowing will also necessarily be at much higher rates due to the higher risk involved.
- The program rewards curtailing service regardless of patient or community need.
- The program discourages application of technological advances regardless of benefit.
- The program diminishes the role of management in negotiating wage changes with non-supervisory employees and in evaluating and implementing alternatives.
- There may be loss of management talent and the field will be less attractive to new management talent because of limited wage opportunities and lack of positive incentives for good performance.
- The assumption that outpatient services is more cost effective than inpatient service has not been confirmed. Such a heavy governmental commitment to this alternative may be dangerous in the long run.
- The program will encourage further fragmentation of the field with resultant lack of coordination of services and higher cost.

We have attempted to briefly highlight the inequities, complexities, deficiencies and dangers in this bill. An attached list enumerates many additional problems. Many alternatives have been offered by other authorites which have a greater potential to constructively correct problems in health care financing which have been created in large part by past government actions.

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Hospital Financial Management Association

Ronald R. Kovener, FHFMA, Associate Executive Director

STATEMENT OF THE HOSPITAL FINANCIAL MANAGEMENT ASSOCIATION

on
S. 1391

THE HOSPITAL COST CONTAINMENT ACT OF 1977
TO THE SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH
OF
THE COMMITTEE ON HUMAN RESOURCES

June 21, 1977

SUPPLEMENTAL LIST OF PROBLEMS

GENERAL: There is no termination date for the "transitional" controls imposed by the bill. While the Secretary of HEW must submit recommendations for permanent reforms in delivering and financing of health care by March 1, 1978, there is no assurance of action and relief from the terms of this transitional program. The "transitional control program" could easily stretch into years; resulting in chaotic conditions in the nation's hospitals and making it much more difficult to design and implement much needed reforms in health care financing. We do not believe that workable reforms in health care financing can be achieved unless government and the private health care sector work together in cooperative atmosphere. The Secretary's Hospital Cost Containment Act creates a divisive influence at a time when cooperation is needed.

The Act does not provide for full financial requirements such as the need for increased working capital. The revenue limit will not allow hospitals to increase revenues to finance increases in accounts receivable and inventories. Severe erosion of the hospital's financial condition is inevitable.

SECTION 101 While the bill indicates that it is effective October 1, 1977, the actual provisions of the bill make it retroactive. Any hospital fiscal year ending after September 30, 1977 is subject to the revenue limits. The entire year is controlled, not just the portion after 10/1/77. Thus, many hospitals are already under the control program. For example, if a hospital's fiscal year began January 1, 1977, the entire year is under control but the final provisions of this bill will not be known until many months of their control year have already passed. Even more troubling is the fact that hospitals could be subject to severe penalties and sanctions imposed by the bill for good faith actions and decisions made before the bill has been enacted. Legislation which would subject hospitals and cost payers to a 150 percent tax on excess payments and exclusion from participation in the Medicare and Medicaid programs would be grossly unfair when non-compliance occurred as a result of actions taken before the legislation was passed.

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SECTION 102 The provision for applying controls to each category of payer will be difficult to administer due to the variations in payment formulas. Blue Cross, local and state government programs, and other payers have developed a wide range of payment methodologies which vary from state to state and even between different groups covered by the same payer. This contributes to confusion in identifying how specific revenues will be treated. Some Blue Cross plans pay a fixed percent of charges and base that percent relation on the past cost experience of the hospital. In this instance is the Blue Cross plan a cost payer or a charge payer? The answer is significant because compliance is measured differently for charge and cost payers. The bill will penalize hospitals if third parties change payment methodologies even if there is no change in the number of admissions. The application of the revenue cap to each category of payer results in further inequity and administrative difficulties for hospitals. Many patients are covered by several payers, possibly both a cost payer and a charge payer (such as Medicare and supplemental commercial insurance). Thus, the hospital would have to prorate a single admission between various categories of payers in order to apply the revenue ceilings. Since the revenue limits are applied to each category of payer, a change in a hospital's proportion of charge payers to cost payers could result in lower revenue limits even though total admissions remained the same. Each cost payer must monitor interim payments to the hospital and retroactively adjust the final payment at year end to comply with the revenue limit. Variations in total admissions for the year as well as in the proportion of patients included in each category of payer will affect the final revenue limit applicable to each category. An interim payment that approximates the final payment per admission allowed by the bill will be difficult to establish. Large retroactive adjustments and the havoc that such adjustments create are practically assured by the bill. A lack of clarity exists as to whether revenue received from charge payers is to be measured before or after deductions for charity care and bad debts. If revenues "received" in an accounting year are equal to gross charges (before charity and bad debts are written off) then a hospital could be penalized for exceeding the revenue limit when in fact it did not "receive" payments equal to its gross charges. Under this bill, hospitals would be doubly penalized for increases in provision of charity service or in the number of patients unable to pay bills. The federal government would tax at a rate of 150% revenues which the hospital will never receive. The term "total revenue...received" is inconsistent with "charges imposed" and confuses the concept of cash basis accounting (money received) with accrual basis accounting (charges imposed).

SECTION 111 There is no recognition of changes in intensity of services and patient mix that will almost certainly occur from year to year. The bill will not allow hospitals to adjust their base year to reflect these changes. Therefore, as more time elapses between the control year and the base period it becomes more likely that hospitals will be unfairly penalized. As a matter of survival, hospitals will be encouraged to utilize the maximum revenue limit as a floor to insure that they are receiving the maximum permissible revenues.

SECTION 112 As a labor and energy intensive industry, the hospital's expenditures for services and supplies are weighted significantly different from those included in the GNP deflator. As pointed out in the American Hospital Association's statement, the hospital's "market basket" is not approximated by the GNP deflator. A single national allowable rate of change also does not consider regional differences in prices for goods and services.

The bill does not clearly indicate whether hospitals which come under the revenue limits established for each category of payer may carry forward the "unused increases."

The "inpatient hospital revenue increase limit" promulgated by the Secretary between July 1 and October 1 of each year will be too late to be effectively used in the hospital's budgeting process. For example, a hospital with a June 30th year end will have already begun its fiscal year before it knows the revenue limit which will apply to the last nine months of its fiscal year.

The Secretary adds to the GNP deflator one third of the difference between the average annual rate of increase in total hospital expenditures and the GNP deflator. As the control program progresses through each succeeding control year this difference will decrease until the revenue limit will be equal to the GNP deflator. Since the GNP deflator does not measure the increased prices hospitals must pay for goods and services, this basis for setting the national control rate is inequitable at the start of the program and becomes more inequitable over time. Revenue limits do not recognize inflation in the prices hospitals must pay as well as increases resulting from increases in intensity of services.

SECTION 113 The bill's treatment of hospitals with increasing admissions is unrealistic and will severely penalize these institutions. Hospitals are precluded from receiving additional revenues for the first 2 percent increase in admissions over the base year. For increases in admissions of 2-15 percent only one-half of the revenues per admission in the base year are allowed. Furthermore, no additional revenues are allowed for admission increases of over 15 percent in the base year.

Percentage changes in admissions are measured from the base year ending in 1976 and compared to each succeeding control year. Hospitals experiencing very moderate increases in admissions will very quickly approach the "15 percent corridor" beyond which all increases in care provided will result in no increases in revenues. Hospitals located in an area experiencing relatively short term population shifts are particularly vulnerable to the unrealistic provisions of the admission load formula. In the very short range hospitals have no effective means of controlling the number of admissions to their institutions. The decision to admit is the physician's, not the hospital administrator's.

SECTION 114 The establishment of the "base accounting year" as the hospital accounting year ended in 1976 is unrealistic. For many hospitals as much as one year or more will have intervened between the time their base year ended and the first year to which controls apply. Section 111 provides for updating the base accounting year to the beginning of controls (October 1, 1977) by allowing a percent increase per admission based on the annual rate in cost increases experienced during the two year period ending with the base year. This ignores completely the actual rate of increase the hospital has experienced between the end of the base year and the start of controls. For example, a hospital with a June 30 year end is allowed to update the base year ending 6/30/76 to the beginning of controls (10/1/77) at a rate equal to the average change in costs for the years ending on 6/30/75 and 6/30/76. It is assumed that costs per admission for the intervening 15 month period increased at a rate based on cost increases experienced prior to and during the base year. During the intervening period between the base year and the start of controls significant intensity increases have resulted from utilization review and PSRO activities in hospitals. The current shift toward providing services in an outpatient setting which historically have been provided in an inpatient setting further impact the intensity problem during this intervening period of time. This impact is ignored by the application of the revenue limits to a base year which is long past and adjusted upward to the control year on a retroactive basis. The establishment of a prior base year from which to measure the allowable increases in revenues will penalize the efficient hospital. The hospital lucky enough to have incurred major startup costs for new services in the base year will have a significant advantage under the bill.

SECTION 115 Exceptions to the inpatient revenue limit can be granted only to the extent necessary to enable a hospital to maintain a current ratio of assets to liabilites equal to current ratio the Secretary estimates is being experienced by the lowest 25th percentile of all hospitals. The source of information for determining the lowest 25th percentile is not specified and we do not believe it is readily available. The current ratio for hospitals is subject to fluctuation and manipulation. The Secretary's estimate therefore is bound to be arbitrary and inappropriate. Even granting exceptions will assure continued poor financial condition and keep the hospital at the brink of financial chaos. The validity of an exception should not be dependent on the continued poor current financial condition of the hospital. A hospital could lose its exception simply because of the fact that as other hospitals approach financial disaster the current ratio for all hospitals will decrease. The maintenance of a current ratio at the 25th percentile of all hospitals could force hospitals to default on capital obligations which were approved under the planning act and would otherwise qualify the hospital for an exception under this bill. Hospitals trying to decide whether to obligate themselves for approved capital expenditures which would meet other criteria for an exception have no way of knowing whether they would meet the current ratio criteria. Financing will be more difficult, if not impossible to obtain for capital projects that are urgently needed in some areas of the country.

The bill requires a hospital to make itself available for an operational review by the Secretary if an exception is granted. Furthermore, the hospital must agree to implement the recommendations resulting from the operational review in order to receive an exception. Qualifications of persons to perform such review is not specified. The cost of conducting such reviews would undoubtedly be high since the Secretary would have to sub-contract to get appropriately qualified reviewers. We question whether any benefits will justify the costs the Secretary will incur in conducting operational review.

SECTION 117 The criteria for exempting state rate review programs seriously undermines state efforts to establish workable rate review programs. The Governor of a state applying for an exception must certify that the rate of increase in hospital revenues for all hospitals in the state will not exceed the rate promulgated by the Secretary in section 112. This will preclude hospitals in states receiving an exception from adjusting their revenue limits for volume increases (section 113) and wage increases of non-supervisory personnel (section 114). It is doubtful that states will want to further penalize their hospitals by obtaining an exemption or incur the administrative costs to monitor the entire state's compliance with the federal program.

SECTION 121 The bill excludes federal hospitals. The only reason we can imagine for the federal government to exempt its own hospitals from the provisions of the bill is a recognition that so little is known about their costs that compliance could not be measured.

The bill also excludes HMO hospitals which will encourage them to duplicate services and equipment already available in hospitals subject to controls. Physicians and other exempted providers will have an incentive to invest in new equipment which the revenue cap prevents hospitals from acquiring.

The bill exempts from the Act new hospitals in existence for less than two years. If the transitional program remains in effect for more than one year the bill does not specify whether "new" hospitals will become subject to the revenue limits.

SECTION 124 It is unclear whether the non-supervisory wage exemption is to be measured from the base year or the year preceeding the control year.

The wage pass-through will disrupt equitable wage and salary programs by causing a compression of wage rates.

A precise and costly allocation between inpatient and outpatient activities is required. The non-supervisory wage exemption only applies to wages paid for inpatient activities. It will be difficult to identify these wages.

If the hospital uses the non-supervisory wage pass-through it uses up a portion of the formula intended for intensity.

The wage pass-through does not provide for the wage related cost increases in fringe benefits.

SECTION 126 Hospitals suspected of changing admission policies in order to reduce services to patients paying less than full charges may be excluded from the Medicare and Medicaid programs. The local Health Systems Agency (HSA) is to investigate complaints and report their findings to the Secretary. We understand that HSAs have limited resources which may not be adequate to conduct fair and impartial investigations. The bill does not specify criteria which the HSA should use in their investigation. Thus hospitals could be subject to severe penalties without a fair hearing and upon the basis of allegations which may not be factual.

SECTION 201 The limits on capital expenditures for after October 1, 1977 does not adequately consider projects already approved and for which financing commitments have been made. The hospital with projects in process would apparently be forced to seek an exception in order to obtain the increased operating funds necessary for the increased depreciation, interest and debt service costs for which it has become committed. The criteria for exceptions are so severe, as noted earlier, that the hospital would undoubtedly be in default of newly issued financing.
This bill will curtail construction by 2-1/2 times the amount of the bill (HR 6655) recently approved by the House to stimulate the construction industry.

Under the bill HSAs may take up to one year to review applications from hospitals for capital expenditures. This is too long a period of time to be practical and the current requirement for a review within 90 days should remain.

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June 1, 1977

Dr
Cc es
Subcommittee on Health & Scientific Research
United States Senate
Washington, D.C. 20510

Dear Dr. Horowitz:

Pursuant to the instructions of your staff, I have enclosed for the record the statement of the Hospital Financing Study Group regarding S. 1391. As a matter of background, HFSG is an informal association of investment banking firms (see attached list) each of which is engaged in the business of designing, underwriting and selling municipal bond issues which are used to supply capital requirements of hospitals and other health care institutions. Each of our member firms counts among its clients many hospitals and other institutions which have a direct interest in many of the issues which the Subcommittee will address during the current hearings. Nonetheless, this statement is presented on behalf of and from the perspective of the financial community rather than from the point of view of the client hospitals.

The scope of our statement is confined to the impact on capital markets of the President's proposal to place a transitional ceiling on hospital reimbursement and curtail capital expenditures. We have commented specifically on the risk of defaults on rate covenant provisions of many existing bond indentures and on the consequences of such defaults on future efforts to raise capital. We have also presented specific recommendations as to modifications which might make for a more financially workable capital expenditure ceiling.

Should you have any questions or response to our remarks please contact Michael George or the undersigned as General Counsel to HFSG. Your conideration of our statement is appreciated.

Sincerely,

Thomas H. Quinn

Enclosure
THQ/t

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FOR THE RECORD

STATEMENT OF DAVID FEARHELLER

June 1, 1977

Mr. Chairman Kennedy, as your Subcommittee is in the process of considering S. 1391, the proposed Hospital Cost Containment Act of 1977, we of the Hospital Financing Study Group are delighted to have this opportunity to submit our remarks for the record.

Over a year ago, in February 1976, Mr. John Vickers, vice president of E. F. Hutton & Co., and my predecessor as Chairman of the Hospital Financing Study Group, appeared before Congressman Rostenkowski s Subcommittee to testify for our Group regarding President Ford's proposal of a flat seven percent ceiling on the rate of increase in Medicare hospital reimbursement. Our Group felt obliged to oppose that proposal essentially because of its arbitrary nature. While we do not find it necessary to greet S. 1391 in a similar fashion, we are not able to give the measure our wholehearted endorsement. Rather, the purpose of our remarks today is informational: we want to share with you and with the members of your Subcommittee, our view of the likely impact of S. 1391, if adopted in its present form, on the private system of health care capital financing.

Identification of HFSG

First, let me explain who we are. The Hospital Financing Study Group is an informal association of the public finance departments of about 30 investment banking firms. Our members include such well-known names as Merrill Lynch, Pierce, Fenner & Smith; Paine, Webber, Jackson & Curtis; and E. F. Hutton, headquartered in major money centers such as New York and Chicago. The Group also includes a significant number of regional investment banking firms located in other parts of the country.

The members of our Group structure and underwrite tax-exempt bond issues and other types of debt financings for hospitals and health care institutions throughout the United States. Among our membership is, I think, the broadest and deepest pool of expertise in the area of hospital capital financing available anywhere in this country. In order to give you some idea of the extent of our members' participation in health care capital financing, I would venture that at least one and usually several of our members have participated in every major health care underwriting account organized during the past three years. In practical terms this means that, during that period, the Hospital Financing Study Group has been represented in every significant attempt to raise health care capital through the issuance of tax-exempt debt instruments. In short, our Group is uniquely qualified to discuss with you the impact of S. 1391 on private-sector financing for health care capital expenditures.

The Importance of Private Capital in Health Care

Before turning to S. 1391 itself, we would like to offer three preliminary observations about the health care capital industry. First, the private sector capital markets have replaced governmental financing for health care capital expenditures. The private system of financing has arisen in large part to fill a vacuum created by the wholesale withdrawal of federal money from this field. The Hill-Burton program marked a major federal effort to assist states and localities in meeting the need for hospital construction. On balance, Hill-Burton has been an enlightened success in bringing adequate hospital facilities to many parts of our country which were previously medically underserved. Indeed, Hill-Burton and other capital programs overshot the mark in some areas where there is now a problem of overbedding. In any event, the flow of Hill-Burton funds and other governmental funding sources has now slowed to a trickle. Private sources of capital have had to fill the gap left by the federal withdrawal.

Health Care Capital Needs Remain High

A second preliminary point is that, while the major source for health care capital has changed in character, the overall need for health care capital financing has remained high. Let me explain this point. Most people in the health care industry would probably agree that little fresh hospital construction is needed at present. By and large we have the hospitals we need. Unfortunately,

too many people leap from this observation--no new hospitals needed--to a simplistic and unwarranted conclusion--no new hospital capital needed. This conclusion could not be farther from the truth. Existing hospitals need a substantial and continuing flow of capital in order to upgrade and modernize their facilities to current standards. In fact, the post-World War II problem of the non-existent hospital has now been replaced by the problem of the substandard hospital. I must emphasize here that I am not speaking of hospitals which are substandard in the sense that they have, like the rest of us, failed to achieve perfection. I am speaking of the many hospitals which must upgrade or replace their existing facilities merely in order to meet current federally mandated standards. For example, hospitals must meet the standards imposed under the Life Safety Code and by the Joint Commission on Accreditation of Hospitals or face loss of federal reimbursement. Indeed, the Department of Health, Education and Welfare estimated in 1974 that the cost of upgrading existing hospital beds to then-current medicare/medicaid standards would run as high as $5 billion annually through 1980. In short, the federal government itself, in its laudable effort to assure high quality hospital services, mandates the continuing need for health care capital expenditures.

High Cost of Health Care Capital

My final preliminary point is that the cost of health care capital, like the cost of nearly everything else associated

with health care, has increased in recent years. In our view, there are two principal factors which determine the cost of capital financing in health care.

First, the interest rates which hospital debt must bear will be partially dependent upon the general interest rates prevalent in the money markets at the time the bonds are sold. Since these instruments must compete in the financial market with other investment alternatives, the rate of return on hospital bonds must be high enough to attract investor interest. Thus, because interest rates in general have escalated in the last few years, the rates which health care institutions have had to pay on their debt instruments have been forced up to meet the competition. During the last six months or so interest rates in general have declined. While hospital bond interest rates have also come down, there continues to be a significant "spread" between hospital bond interest rates and rates on otherwise comparable debt instruments.

This higher cost of health care capital can only be explained with reference to the second major factor which determines the interest rate on a hospital's bonds: the risk associated with the investment. The greater the risk of default, the higher the interest rate required to induce investment. And, in addition to the actual risks involved in an investment, there may be "perceived risks" of equal importance as a result of vacillating federal policy. At the hazard of oversimplifying

the complicated workings of the bond markets, it is the difference in risk, both actual and perceived, which is largely responsible for the fact that on a given day the federal government, whose bonds are backed by its taxing power, is able to sell debt instruments at a rate far lower than that required to sell the debt instruments of a fledgling corporation, whose debts are backed only by its prospects for future success.

The risks and uncertainties inherent in the tax-exempt bond of a hospital fall somewhere between the extremes of the federal government and a fledgling corporation. I will turn to the impact of S. 1391 on the risk in hospital capital financing in a moment. Suffice it to reiterate here that the high cost of hospital debt financing is the product of (1) high interest rates in general and (2) the actual and perceived risk in hospital financing.

Revenue Ceiling Avoids Long-Term Incentive Approach

Title I of S. 1391 proposes to establish a transitional program for constraining the upward spiral of hospital costs by limiting the amount of revenue which a hospital could receive for inpatient services. President Ford's proposal of last year took a similar approach toward hospital revenues and we opposed it. Indeed, we are generally uncomfortable with any proposal which, like S. 1391, approaches the problem of cost rises by the simple but crude device of a broad-gauged cap on revenues.

We feel that the reimbursement cap approach treats the symptom--soaring hospital reimbursement--rather than the disease itself--the lack of real incentives to hold down hospital costs. Thus we generally prefer an incentive reimbursement approach to the problem as opposed to a reimbursement cap approach. For example, we looked with favor on the incentive reimbursement proposal contained in Section 10 of Senator Talmadge's S. 3205 of last year. We are heartened to know that Senator Talmadge has recently introduced comparable legislation into the Senate.

Despite our general reservations about the reimbursement cap approach, we believe that Title I of S. 1391 is a distinct improvement over President Ford's proposal of last year. First, Title I is intended to be a transitional program. Thus, although it would be objectionable over the long-term, it is more palatable as a short-term expedient. We note, however, that the bill is not self-terminating. We are all too familiar with "temporary" and "transitional" federal programs which tend toward permanence. Section 2 of the bill requires HEW to propose by March 1, 1978, a permanent replacement for the transitional program of Title I. Without wishing to derogate the many excellent efforts of that large agency, we must note that HEW has missed deadlines in the past, even deadlines which are statutorily mandated. We feel that a self-terminating clause should be inserted in Title I. Such a clause would tend to prevent institutionalization of the

program and would provide an additional incentive for HEW to comply with the Section 2 mandate that it propose a more permanent alternative. Let me reiterate our general approval of a realistic incentive approach to the problem of soaring hospital costs; we hope that HEW's proposal will turn in that direction.

The specific reimbursement cap which would be generated under S. 1391 are preferable to last year's flat 7 percent cap. Each year's cap determined under the formula set out in Section 112 of the bill would be set roughly at the general rate of inflation plus an allowance for the difference between the rate of general inflation and the higher rate of increase in hospital costs. Basing the cap on the general rate of inflation would allow a hospital to accommodate many of the inflationary price increases which are passed on to it by its suppliers. Allowing the extra margin in the cap which reflects recent rises in hospital costs would allow the hospital a little extra maneuvering room for coping with the hitherto intractable and extraordinary cost rises in health care.

Title I is also an improvement over President Ford's proposal in that it contains certain exceptions. Section 115 of the bill allows an exemption for any hospital which experiences a sudden and sharp rise in its allocable inpatient costs as a result of a capital expenditure. We applaud this exception as a legislative reflection of a well known business fact: even

the most meticulously planned and most thoroughly justified capital expenditures can be counted on to result in higher costs more quickly than higher revenues, even though the higher revenues may compensate in the long run.

We note with some concern, however, that in order to qualify for this exception a hospital must first demonstrate that it is in comparatively poor financial health. Specifically, under Section 115(a)(2), its current ratio of assets to liabilities must place it in the bottom quarter of hospitals in terms of this variable. The apparent effect of this threshold requirement for the exemption is to provide a special incentive for financially unsound hospitals to undertake capital expenditures. In effect, a hospital which has a sharp rise in capital costs must meet a needs test for an exemption from the reimbursement cap. Is this the result intended by the framers of the bill?

We note also that the bill simply calls on the Secretary of HEW to estimate that ratio of assets to liabilities which is experienced at the 25th percentile among hospitals. How will HEW arrive at this estimate? What criteria will it use? We hope that these and other hearings will produce enough in the way of standards to assure that the estimate is not without foundation.

Reimbursement Cap Will Ultimately Exacerbate Health Care Inflation

Having cited several features of Title I, which make it more palatable than the Ford proposal of last year, let me hasten to say that the Hospital Financing Study Group cannot fully endorse this proposal in its present form. We must withhold our endorsement from Title I because we believe that it will raise the cost of private-sector health care capital financing and because these higher costs will be borne by patients and, to an increasing degree, by the government itself. You need only refer to my remarks noted above. The interest paid by hospitals on their debt instruments is the cost to the hospital of raising private sector capital. That cost is a function of two variables, the prevailing interest rates in general and the actual and perceived risk in hospital financing. We don't know what Title I might do to interest rates in the whole economy; they are beyond the scope of this bill and beyond the scope of our remarks. We can, however, surmise all too well what Title I will do to the risk factor in hospital financing: the risk will go up. This is so because the reimbursement, without an exception for pass-through of debt servicing costs, puts a question mark over the hospital's ability to repay its debt.

A simple example will explain my point. Many hospital financings have been secured in the past with a "rate covenant". Under a rate covenant, the borrowing hospital agrees with the investors that the hospital would keep its rates (and

therefore its revenue) high enough to service and pay back its debt. The rate covenant, enforceable at law, is a form of security for the lender which has routinely been written into trust indentures over the last several years. Under Title I, such a rate covenant would be meaningless and unenforceable the moment the hospital, in raising its rates to meet its capital costs, bumped into the reimbursement cap. A hospital operating under such an indenture would be caught between a rock and a hard place: if it raises its rates above the cap it breaks the law; if it doesn't, it defaults on its obligations, damaging its credit rating.

It is precisely this scenario and the spectre of wholesale defaults which raises both the actual and the perceived risk in private-sector health care capital financing. The result is inevitable: by injecting more risk into the market, Title I will raise the cost of private capital. This added cost will ultimately be borne by the consumer, either directly as a private patient or indirectly as a taxpayer.

Role of Local Planning Groups in Rationing Capital Expenditures

I turn now to Title II of S. 1391, which proposes certain governmentally imposed limitations on expenditures. Specifically, Title II would give the Secretary of HEW the authority to set an overall national limit on capital expenditures and to establish a supply ceiling and an occupancy standard for hospital beds. Thus, Title II of S. 1391 continues in the line

established by the Section 1122 program, by the National Health Planning and Resources Development Act, and by the various state certificate of need laws: it would take us a further step along the road of increased planning in the health care capital process.

The collective experience of the members of our Group in raising private money to finance hospital modernization suggests one simple axiom to characterize the role of planning in the hospital capital process. It is this: sound planning at the local level makes our job easier and less expensive. Take the example of a hospital which wants to upgrade its existing facility to contemporary standards. We find a direct correlation between the thoroughness of the planning for this modernization and the attractiveness of the underlying bonds as an investment. The better the planning, the sounder the investment. The sounder the investment, the easier it is for us to raise private capital at comparatively low rates of interest. At the bottom line, our experience tells us that good hospital planning lowers the cost of capital from private sources and results in a savings to the reim bursement system.

Thus, the Hospital Financing Study Group favors rigorous application of planning screens at the local level. We believe that new capital proposals should pass through the most careful review by the HSA and again when applying for certificates of need from the State Health Planning and Development Agency.

More specifically, we support those portions of Title II which strengthen the state certificate of need programs. It is beyond our province of expertise to say whether the Title II supply ceiling of 4 beds per thousand population and the occupancy standard of 80 percent are appropriate norms for certificate of need review. Others are better qualified to comment on precisely where these norms should be pegged. We can, however, and do, state our support for the Title II approach of a federally established but flexible supply ceiling and occupancy standard for certificate of need review. We think that specific quantitative norms will put more teeth in the planning process. We also support the other provisions of Title II which strengthen the planning process. For example, Section 203 of S. 1391 would be a valuable and needed planning tool. It would take away the tax exempt status for bonds which are issued to finance health care capital improvements when these improvements have not passed certain planning screens. Section 203 makes sense: it would punish in the pocketbook a hospital which fails to secure appropriate planning approval for its capital expenditures.

Justification Needed for $2.5 Billion Capital Ceiling

It is in the light of our overall support of health care planning that our problems with the $2.5 billion capital limit arise. This part of Title II, like the reimbursement cap of Title I, would take a broad-gauged and crude approach to a complex and subtle problem. The $2.5 billion capital limit of

Title II makes the same error as the reimbursement cap of Title I: it would treat the symptoms--in this case rising hospital capital expenditures--without treating the disease--an inadequate planning process. That approach may be sound medicine in some cases, but it is not sound public policy.

More specifically, what is the origin of the $2.5 billion figure? You have heard several witnesses testify that this figure is not high enough to meet the capital needs of the nation's hospitals. Our calculations suggest that it is about one-half the current annual rate of hospital capital expenditures. How is this figure related to the present and projected capital needs of hospitals? What will be the effect on hospitals of such a sudden and drastic constriction of the flow of capital funds? Our expertise lies in raising capital, not in drafting a national hospital capital budget. But it seems to us that the $2.5 billion capital limit would apply a fiscal tourniquet to the hospitals' capital artery. Such a draconian measure requires thorough justification. Setting the national figure is essentially a decision of public policy and we leave that decision to those better qualified to make it, noting only that the $2.5 billion appears to us to be an unrealistically low figure.

Another feature of the Title II capital limit which we find troubling is that it will be permanent. One of the saving graces of the Title I reimbursement cap is that it is transitional. The Title II capital limit, on the other hand, does not

propose to be a temporary expedient. Evidently the drafters here intend that $2.5 billion will be the national hospital capital limit for the indefinite future. There is not even an allowance in Title II for administrative adjustment above the $2.5 billion limit to allow for inflation. We find the permanence of the limit to be virtually without precedent. Congress is here being asked by the Administration to place an absolute and permanent budgetary ceiling on the capital expenditures of an entire industry. The Hospital Financing Study Group recommends strongly that the Congress make the capital limit of Title II, like the reimbursement cap of Title I, a transitional and self-terminating phase of the war on soaring hospital costs.

Our group is also troubled by the methods proposed in Title II for allocating the capital limit. We think that the population-based allocation which is proposed for the first 18 months of the Act's life is likely to be unfair to medically underserved states. Again, this is an area where other witnesses may be more expert, but our impression is that the problem of overbedding tends to be greatest in the most populous and urbanized states. If this is so, then the population-based allocation formula will send the largest portions of the scarce allowable capital to those states where hospital capital is least needed. Inevitably, the medically underserved states will suffer. In short, given the national maldistribution of hospital services, the population-based allocation is a bad way to slice the $2.5 billion pie.

Even after the first 18 months, at a time when HEW will consider other factors such as variations among states in the need for hospital facilities, equipment, and modernization, problems will remain. To take the most obvious one, the $2.5 billion may simply be too small to meet the nation's needs. Hence, the share of that figure given to a medically underserved state, even though determined by a needs-based allocation formula, will likely itself be too small to meet that state's needs. In the case of a hospital which is in need of upgrading to meet current federally mandated standards there may be a particular hardship. Take the example of a hospital which needs new capital to upgrade in order to avoid loss of federal reimbursement. Suppose further that the state's share of the national limit is simply not large enough to accomodate this particular hospital. Here again we see a hospital caught between a rock and a hard place, unwitting pawn to two competing federal mandates. The hospital will not be able to get a certificate of need for the upgrading. If it goes ahead with the upgrading it breaks the law. If the hospital defers the improvement it faces loss of reimbursement. Either way, the hospital loses. As specific relief for this hardship situation, we recommend that S. 1391 be changed to allow a certificate of need to be issued without regard to the national capital limit to any hospital which must make capital improvements in order to meet currently mandated standards.

Let me reiterate our Group s support for portions of Title II. We favor the rigorous application of local and state planning screens to proposed hospital capital expenditures. We have found that the best planned hospital capital developments become the most marketable investments. Therefore we favor those provisions in Title II which would strengthen the planning process. We are, however, concerned with the $2.5 billion hospital capital limit. We think this figure may be too low to meet the nation's needs. We also think that this figure should be transitional rather than permanent. Finally, we feel that the proposed formulas for allocating the $2.5 billion will work hardship on medically underserved states and on paricular hospitals in need of upgrading.

The Kansas Hospital Association

FRANK L GENTRY
Executive Director

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P.O. Box No. 417 233-7436

KANSAS HOSPITAL ASSOCIATION

June 15, 1977

Stuart Shapiro, M.D.
Subcommittee on Health
and Scientific Research
Committee on Human Resources
U.S. Senate
Washington, D.C. 20510

Dear Dr. Shapiro:

Attached is the position statement of the Kansas Hospital Association on S. 1391, the Hospital Cost Containment Act of 1977. We request that you include this statement in the record of hearings to be held on S. 1391 by the Subcommittee on Health and Scientific Research of the Committee on Human Resources.

Respectfully yours,

Frank L. Gentry

Frank L. Gentry
President

FLG:ca
Enclosure

The Kansas Hospital Association

FRANK L GENTRY
Executive Director

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KANSAS HOSPITAL ASSOCIATION

STATEMENT OF THE
KANSAS HOSPITAL ASSOCIATION
TO THE SUBCOMMITTEE ON HEALTH AND
SCIENTIFIC RESEARCH, COMMITTEE ON HUMAN RESOURCES
ON S. 1391

June 15, 1977

The Kansas Hospital Association, speaking for its 165 member hospitals and 110 personal members, appreciates the opportunity to present this written statement for the record of the hearing of the Subcommittee on Health and Scientific Research of the Committee on Human Resources on S. 1391, the Hospital Cost Containment Act of 1977.

The Kansas Hospital Association and its member hospitals recognize the very serious nature of the problems created by the continuing increase in the cost of providing the high quality hospital care the American public deserves and has come to expect. No one is more acutely aware of the actual increases in per patient day and per admission charges for hospital stays than are our hospital administrators. Also, we assure you that no one is more committed to ensuring that the health care dollar is wisely spent than are trustees and administrators of the non-profit hospitals in the state of Kansas.

Since the subcommittee has heard from other sources that many of the reasons for increases in hospital costs are outside the control of hospital administration and that there are many and varied

activities being undertaken by hospitals to operate in the most efficient and effective manner, the Kansas Hospital Association will not repeat a detailed discussion of these subjects at this time. Our statement will be confined to comments in three major areas:

1. A brief discussion of the kind of realistic government programs that we feel must be undertaken if the subject of rising health care costs is to be addressed in a successful manner.
2. A discussion of why S. 1391 is not even a transitional solution to the problem of increasing health care costs, and why the Kansas Hospital Association feels this legislation must be defeated.
3. Specific comments concerning certain sections of S. 1391 that are particularly inappropriate for application in rural areas.

The Hospital Cost Containment Act of 1977 assumes that the only individuals making decisions affecting hospital costs are those people responsible for the management of hospitals. This simply is not the case. Many parties, including physicians, Blue Cross Plans, commercial insurance companies, the general public and the government daily make decisions that ultimately result in increases in hospital costs. For any governmental cost control program to be effective, it must address all of these decision-makers, instead of placing restraints on only one - hospital management.

Due to the complex nature of the health care system, it closely resembles the nationwide energy situation, and an approach such as was developed by the Administration in dealing with the energy problem is

one kind of realistic long-range approach that might work with the health care system. The failure of S. 1391 to take into account the role of physicians, the public, Blue Cross, commercial insurance companies, and the government itself, and the effort to secure savings without restraining all of the cost decision-makers, ensures that the ultimate impact on our Kansas hospitals of such legislation could very well be bankruptcy.

In addition to its inappropriate singling out of only one component of the health care system for control, S. 1391 must be defeated because its control mechanism is unsound in concept. This bill proposes a uniform percentage method of charge control for a highly varied industry. Such a simplistic and arbitrary mechanism can only result in certain institutions being treated in a wholly unreasonable and prejudicial fashion.

The Hospital Cost Containment Act of 1977 is unfair to the hospital industry because it represents wage and price controls on a single sector of our national economy. To expect such controls on hospitals to be successful without having similar controls on the prices of goods and services that hospitals must purchase appears to be totally unrealistic. It further appears that this bill is so complex that it will require a huge bureaucracy to administer. The expense of this bureaucracy and the additional expense that would be required on the part of hospitals to cope with the requirements of the legislation in changing reporting systems, engaging consulting firms to assist in appeals, and in processing appeals, would seriously undermine any cost savings that are heralded by advocates of the bill.

Finally, the Kansas Hospital Association objects to the Hospital

Cost Containment Act of 1977 because we feel it would effectively stop continued progress in the care of our patients. The historical commitments of Kansas hospitals are to provide high quality patient care to the citizens of Kansas, and to be able to respond appropriately as the health care needs of our statewide community change. This bill would prohibit us from continuing to upgrade the care we provide and would restrict the ability of Kansas hospitals to respond to changing health care needs.

In addition to these general shortcomings, the Hospital Cost Containment Act of 1977 also fails to take into account the unique nature of the provision of hospital services in rural America. A major example of this concerns the proposed restriction on capital expenditures. While we understand the need for restraint in the building and remodeling of hospitals, we feel the method proposed in S. 1391 is so inflexible as to be unworkable. The standards of four beds per 1,000 and an 80 percent occupancy rate demonstrate the lack of understanding by the bill's authors of hospital operations, particularly those in a rural area. In small hospitals, occupancy rates fluctuate widely, yielding a lower overall occupancy rate; however, in small hospitals the number of beds to begin with is so small that even at a 70 percent occupancy rate there are very few beds for standby purposes, in the event of natural disasters, epidemics, accidents, or other unanticipated peak demands for care.

The exceptions process provided for in the bill appears to be totally unreasonable in that it does not permit an exception to be granted until a hospital is virtually insolvent. And, if the hospital is able to receive an exception, an HEW review team can make binding recommendations that will virtually eliminate the autonomy of the hospital

board, medical staff and administration. The Kansas Hospital Association seriously doubts whether the Department of Health, Education and Welfare has sufficient background and expertise to make realistic recommendations for improvement in the small rural hospitals which predominate in our state.

A final example of the lack of understanding of rural hospitals is the inapplicability of many of the portions of the bill concerning the question of public disclosure by rural hospitals. S. 1391 presumes that public disclosure will provide to consumers the ability to comparison shop and purchase the cheapest available hospital services. In Kansas, 130 hospitals are located in single hospital communities. Many of these are the only hospital in the entire county. Thus, it is obvious that the public disclosure requirements in S. 1391 will not lead to price competition between hospitals in rural areas, and further serves to demonstrate the Administration's lack of understanding of hospital economics for rural hospitals.

In summary, the Kansas Hospital Association urges that the Hospital Cost Containment Act of 1977 be defeated because:

1. It fails to address the problem of rising hospital costs in a broad-based, realistic manner;
2. The bill essentially mandates single sector wage and price controls;
3. It attempts to regulate a highly varied industry in a uniform fashion; and
4. For Kansas, many sections are particularly inappropriate for rural areas.

We appreciate the opportunity to provide these comments.

Kentucky Hospital Association

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June 20, 1977

Stuart Shapiro, M.D.
Subcommittee on Health and
Scientific Research
Committee on Human Resources
U.S. Senate
Washington, D.C. 20510

Dear Dr. Shapiro:

Transmitted herewith you will find the prepared statement of the Kentucky Hospital Association in opposition to S. 1391, the Hospital Cost Containment Act of 1977.

As you will note, this testimony is broken into three major subdivisions. The first section challenges the rationale and intent behind S. 1391, details the particular facts and circumstances of cost containment activities in the state of Kentucky since 1950.

The second relates to the necessity for encouraging a national health care policy on cost containment that would enable local hospitals to be able to maintain their vitality so they can continue to provide the quality and scope of services demanded by their patients.

The third portion of the document relates to a very brief summary of how the bill impacts some of Kentucky's rural hospitals which are the backbone of Kentucky's health care delivery system.

In the interest of brevity this impact statement was limited to three small rural hospitals; however, additional examples of how S. 1391 unfairly treats Kentucky hospitals can be furnished upon your request.

Sincerely,

William S. Conn, Jr.
Executive Director

WSC:sls

Enclosure

TESTIMONY AND PREPARED STATEMENT OF THE KENTUCKY HOSPITAL ASSOCIATION BEFORE THE SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH, COMMITTEE ON HUMAN RESOURCES ON S. 1391

Adopted by the KHA Board of Trustees

May 27, 1977

The purpose of this written testimony on the Hospital Cost Containment Act of 1977 (S. 1391) is to support the position of the American Hospital Association presented by Leo J. Gehrig, Senior Vice President of AHA, before the Health Subcommittee on May 24, 1977. This statement of the Kentucky Hospital Association is made on behalf of its membership which represents 96 percent of all the licensed acute care hospitals in the Commonwealth of Kentucky and includes mental health care facilities, extended and long-term care facilities, primary care centers, hospital-based schools of nursing, state and federal hospitals, and a number of personal members.

This document is intended to localize the position taken by the AHA by expressing the views and attitudes of Kentuckians on S. 1391; to discuss some of the progress Kentucky has made in areas of hospital cost containment; and to share some very basic and fundamental concerns which Kentuckians have in regard to developing national health policy with regard to hospitals under the Carter Administration. Hopefully, this statement will aid the Health Subcommittee in its deliberation on the important issue of the rising cost of hospital care. KHA and its member hospitals appreciate the opportunity to contribute to the record, our collective opposition to this proposed legislation.

* * *

I. S. 1391 OBJECTIVE IS RATIONING NOT COST CONTAINMENT

Kentucky's hospitals sense a terribly improper indictment of the hospital system in the rationale and design of the Hospital Cost Containment Act of 1977. This appearance of indictment is based upon statements made by the architects and proponents of S. 1391, including the President of the United States and the Secretary of HEW. Perhaps, this indictment is because our hospitals have been responding to the public demand for more and better quality hospital care whereas it appears strongly that the President's objective is to provide more services at a lower cost. Public pronouncements in support of S. 1391 appear to have been designed to create a bad image of our modern hospitals by downgrading the integrity of hospitals and their ability to effectively manage and provide hospital services and to imply that hospitals have not been willing to cooperate in resolving the problem of rising health care costs. Hospitals in Kentucky which might well be considered "obese", as described by the Secretary of HEW, are such because they are burdened with the scope and range of hospital care expected and demanded by physicians, patients, and community hospital leaders.

President Carter and Secretary Califano, at a White House briefing on April 25, 1977, started the campaign to sell the public on the Hospital Cost Containment Act of 1977. The Secretary of HEW said that hospital costs had been first targeted because "...they (costs) had been rising so recklessly...". In the course of his statement, Secretary Califano said that hospitals were "obese", not "trim". Under questioning, the Secretary said that hospitals could clearly survive under the revenue "cap" because there were many things which could be cut to save money.

Earlier, in February, the President was reported to have expressed a more extreme view of this country's hospital system, when the Secretary created the Health Care Financing Administration which placed Medicare and Medicaid programs under a single tough-minded, cost conscious administrator, which was long overdue and appreciated. In the February 18, 1977, edition of the Louisville Times, an article described that reorganization from the President's point of view:

"The agency could begin to weld what Jimmy Carter has called 'a haphazard, unsound, undirected, inefficient, nonsystem, which has left us unhealthy and unwealthy at the same time' into a health care system that could operate under a comprehensive health insurance plan without breaking the federal budget."

Remarks made by the President, the Secretary of HEW, and others have enraged the hospital community in Kentucky and raised the eyebrows of those citizens who are concerned about the rising cost of hospital care in Kentucky. This reaction is based on efforts Kentucky's hospitals have made toward many cost containment and cost avoidance activities. This commitment is easy to establish by providing a brief overview of such activities during the past 25 years.

1. Contractual Rate Review Practiced Since 1969:

Efforts in cost containment began almost 10 years ago when the leadership of KHA and Kentucky Blue Cross-Blue Shield, Inc., developed a statement defining and specifying the financial needs of Kentucky's hospitals. Modeled after the AHA Statement on Financing and Guiding Relationships, this document was approved by the KHA Board of Trustees and ratified by its membership in 1969, and provided the basis and guidelines for a contractual rate review program between Kentucky's hospitals and Blue Cross. Kentucky was one of the first states to have voluntarily provided, in cooperation with Blue Cross, for a contractual rate review program.

2. Early Health Planning Practiced by Kentucky's Hospitals:

In this same document there was included a strong policy statement on planning designed to achieve a more effective and efficient allocation of hospital resources to prevent duplication of facilities and services. The objectives of this statement on planning were eventually fully realized in 1972 when the Kentucky General Assembly passed a strong certificate of need and licensure law (KRS 216.405 through 216.485) designed to place planning responsibility in an independent agency of state government with its own governing authority.

3. Certificate of Need and Licensure Law Supported by Hospitals:

Kentucky has been operating under a strong Certificate of Need and Licensure Law since 1972 before the enactment of P.L. 93-641 and subsequent federal regulations establishing federal certificate of need requirements. Today, many of the Kentucky regulations are more stringent than their federal counterparts promulgated under P.L. 93-641. Kentucky has only increased its bed population by 11 beds since the Certificate of Need and Licensure Law was enacted. Therefore, Kentucky has not contributed to the national problem of over-bedding.

4. Utilization Review Practiced Long Before It Was Federally Mandated:

In another area of fundamental reform with important cost containment overtones, KHA's administrators and trustees endorsed national goals and objectives for improved hospital utilization review (UR) and medical audit. Kentucky hospitals performed UR long before it was mandated by federal regulations promulgated by the Social Security Administration. Support of UR principles has been difficult given the constraints of revised reimbursement policies promulgated by federal agencies which collided with the traditional standards of quality, appropriateness, and need of care. The thrust in this change in emphasis by govern-

mental agencies caused outright rebellion among some medical staff members in many Kentucky hospitals. Notwithstanding such problems, Kentucky's Professional Standard Review Organization (PSRO) program has been launched with the support of Kentucky's hospitals and will continue to have their support in the future.

5. Cost Containment and Cost Avoidance Activities:

From an operational standpoint, many Kentucky hospitals have practiced joint ventures and cost avoidance programs for a number of years. A brief summary of some of these endeavors are discussed below.

(a) Louisville Medical Center, Inc., Formed in 1950:

Long before increasing hospital costs became a national issue, on May 31, 1950, the Louisville Medical Center, Inc., was formed. This organization's principle aim was for the development, through coordinated planning and joint ventures, of a comprehensive medical center complex of hospitals and allied health organizations to serve the citizens in the Louisville-Jefferson County, Kentucky area.

Today, the Louisville Medical Center, Inc., provides steam and chilled water from its central plant to Jewish Hospital; Norton-Children's Hospitals, Inc.; Institute of Physical Medicine and Rehabilitation; Louisville General Hospital; Methodist-Evangelical Hospital (such hospitals contain 1,644 acute care beds); the University of Louisville Health Sciences Center (including the Schools of Dentistry and Medicine); The American Red Cross, Louisville Area Chapter; The Louisille-Jefferson County Department of Health; the Health and Speech Centers, Kentucky Easter Seal Society; and the Bingham Child Guidance Clinic.

In addition, central laundry services are provided to all of the hospitals except for Methodist-Evangelical Hospital and the Louisville-Jefferson County Department of Health. Since 1969 a group purchasing program has been available to all hospitals just mentioned, all allied health care centers, plus SS. Mary & Elizabeth Hospital located in Southwest Jefferson County. The utilization of this approach using a central steam plant for energy requirements, the cost benefits associated with a group purchasing program and a central laundry, has resulted in the conservation of capital, land, and cost avoidance from non-duplication of personnel requirements to operate separate services for each institution.

(b) Centralized Laboratory Services Established:

Three hospitals in the Louisville Medical Center, Inc. group operate a central laboratory which has resulted in considerable cost savings to patients they serve. Today, the SMA-18 laboratory test is being performed at a total cost less than $2.25. This cost is approximately 25 percent of the total cost an individual hospital might be required to spend on the same procedure.

(c) Baptist and Catholic Hospitals Cooperate in Joint Venture:

Although most of these activities referred to above have been in existence for a considerable period of time, recently Kentucky Baptist Hospital and St. Anthony Hospital in Louisville committed their resources for the purpose of a joint venture in shared services. Those two institutions will serve the

Highlands area of the city of Louisville in a combined effort to provide more services to those citizens at a reduced level of cost.

(d) Cost Avoidance and Containment Activities Reduce the Cost of Hospital Care in Jefferson County:

Indeed, all of these actions referred to above must have contributed to a favorable level of hospital costs in the Louisville Metropolitan area when contrasted to other comparable cities in the country. According to information recently released by the American Chamber of Commerce Researcher's Association, for the second quarter of 1976, Louisville hospital costs ranked the lowest and were 21.5 percent below the national average for metropolitan hospitals and 14.2 percent below the next lowest comparable city--Nashville. This statistical comparison of cities included Indianapolis, Cincinnati, Atlanta, St. Louis and Nashville.

(e) Western Kentucky Hospital Services, Inc.:

In September 1968, Western Kentucky Hospital Services, Inc. (WKHS), was incorporated by Jennie Stuart Memorial Hospital, Hopkinsville; Hopkins County Hospital, Inc., Madisonville; Muhlenberg Community Hospital, Greenville; Community Methodist Hospital, Henderson; Caldwell County War Memorial Hospital, Princeton; and Trigg County Hospital, Cadiz, for the purpose of establishing a central laundry facility to provide laundry service for each of the institutions. In addition to the original incorporators, today there are five associate members who belong to the organization and they are: Livingston County Hospital, Salem; McLean County General Hospital, Calhoun; Crittenden County Hospital, Marion; Grayson County War Memorial Hospital, Leitchfield; and Breckinridge Memorial Hospital, Hardinsburg. Less than five months after the central laundry venture was undertaken, WKHS acquired a warehouse and began a central purchasing program for medical/surgical supplies. This activity was very successful and led to a new venture--a central unit dose and drug packaging program for the member hospitals. Later, WKHS began providing a centralized microfilming of medical records and an inservice education library for the member hospitals. In 1972, the organization undertook to promote and fund an industrial engineering program which has been met with a large degree of success for not only the member hospitals but other nonmember users in the Western Kentucky area. The latest activity in which the WKHS has expanded is in regard to providing a central printing shop for all member hospitals. The budget for this organization has grown from $660 thousand in 1972 to more than $2 ½ million for 1977. In addition to the tangible direct cost benefits which have accrued to the participants in this program, are reductions of indirect costs in regard to the conservation of capital which was achieved vis-a-vis a central laundry service, and the need to keep reduced inventories of supplies as a cost of the warehousing activity in Hopkinsville.

(f) Appalachian Regional Hospitals, Inc., System:

Tightly controlled central services, including maintenance and engineering, accounting, pharmacy, data processing, personnel and labor relations, is the characteristic of the Appalachian Regional Hospitals, Inc., a chain of 10 hospitals operating in Eastern Kentucky, Virginia and West Virginia. In addition to the management of that chain, it provides regional consultative service among the large and small hospitals in the chain to relieve and reduce the demands of highly skilled professional personnel in each hospital in areas such as medical records, laboratory and dietary functions.

(g) Baptist Hospitals, Inc.:

Another chain operation which utilizes a common data processing system, purchasing, and unified management services is Baptist Hospitals, Inc., consisting of five hospitals in the state of Kentucky located in Paducah, Louisville and Lexington.

(h) Management Engineering Program:

In addition to individual and joint efforts of hospitals, in January of 1975 the KHA launched a statewide management engineering program whose services are available to all member hospitals. To date, projects have been concluded in the following areas saving Kentucky's hospitals hundreds of thousands of dollars:

*Supervisory Training
*Business Office Procedures Analysis
*Emergency Room Comparative Analysis
*CSR Staffing Analysis
*Dietary Staffing and Procedure Analysis
*Material Management Study
*Maintenance Program Developments
*Medical Records Analysis
*Radiology Staffing Study
*Pharmacy Management-Audit Study
*Rehabilitation Medicine Services Staffing Analysis
*Nursing Study
*Administrative Procedures Analysis
*Laboratory Charge System Analysis
*Wage and Salary Administration Program
*Job Descriptions
*Consulting Dietary Services

6. Other Examples of Shared Services and Joint Ventures Will Be Submitted:

There are many other examples of cost containment and cost avoidance programs in the state of Kentucky. Just a few of these have been discussed in this statement; however, should the members of this committee desire further evidence of these activities, the KHA will be glad to submit such additional information.

7. Summary of Activities and Cost Story in Kentucky:

Kentucky's hospital leadership feels these developments, in which KHA has played an active role, have contributed to the success of the hospital cost story in Kentucky. To illustrate this point, your attention is invited to information published by the American Hospital Association, which shows that patients in Kentucky's community hospitals, during 1975, had an average adjusted per diem cost of $98.33 in contrast to the national figure of $133.81. This average adjusted per diem cost outperforms the national average by 27 percent. Further, in respect to the average cost per admission or case, because of a lower length of stay, patients in Kentucky's community hospitals paid on an average only $694.40, or one-third less than the national average of $1,030.90.

II. CONGRESS MUST ACT TO ENCOURAGE LOCAL HOSPITALS TO MAINTAIN THEIR STRENGTH AND VITALITY SO THEY CAN CONTINUE TO PROVIDE THE QUALITY OF SERVICE THE PEOPLE EXPECT AND DEMAND

The environment in Kentucky has been one of cooperation among all health care providers, local and state governments, consumers, and private nonprofit and commercial payors in areas of cost containment and devotion to quality care. This spirit of cooperation of which we speak is characteristic of Kentucky's health care community and has contributed to the progress and the resolution of complex health care issues in a responsible and careful manner.

The duly constituted hospital boards of trustees of Kentucky's hospitals, within the existing framework of federal and state requirements, establish the rates and charges for hospital services in Kentucky, monitor the quality of care, and set short and long-term objectives for their respective hospitals while balancing the cost of care with the maintenance of the hospital's financial stability and need for survival. This bill would substitute the sound discretion of the local community hospital board as to what's best for the local hospital community and the level of services to be provided its patients for the nondiscretion of the federal-mandated prerogatives set forth in S. 1391. This substitution will impede seriously the traditional relationship of hospital's partnership with government which in the past has been characterized by due respect that has recognized and accommodated the local desires and needs of the patients hospitals serve.

The citizens of Kentucky, although concerned about rising hospital costs, have not demonstrated such public dissatisfaction with the existing system as would justify the extreme measures announced by S. 1391. Local citizens take great pride in their hospitals and desire that their institutions remain viable, healthy, and capable of meeting their increased need for care.

Kentucky's hospitals have been concerned about the numerous pressures beyond their control that drive-up the cost of hospital care. Hopefully, Congress will work cooperatively with hospitals to identify and control hospital cost inflation in a responsible manner rather than taking the simplistic approach of condemnation of the hospital community. Hospitals did not increase the demand for increased services. Nor do hospitals admit patients, order tests, prescribe treatment or medication. Should S. 1391 be enacted, a rationing of health care in hospitals will become a reality over some period of time. Kentuckians are opposed to this as an objective but if forced upon hospitals, Congress must have the courage to accept the responsibility for such reductions in services and not require hospitals to make those decisions alone.

Finally, we would like to say again that KHA supports the statement presented by American Hospital Association Senior Vice President, Leo J. Gehrig on S. 1391:

> "It is our strong opinion that this bill is inequitable in design, wrong in concept, and impossible to administer. We believe that its enactment would seriously jeopardize the present and future ability of hospitals to provide quality care to the American people."

We submit that hospitals are a product of society and that the solution to the costs of hospital care must be dealt with by society in total. The proposed Hospital Cost Containment Act of 1977 is equivalent to the parent punishing a rebellious child who is a direct result of the parent's action.

III. THE EFFECT OF S. 1391 ON SELECTED KENTUCKY HOSPITALS

In its testimony before this subcommittee on May 24, 1977, the American Hospital Association correctly said that S. 1391 was "inequitable in design, wrong in concept, and impossible to administer". Now the Kentucky Hospital Association will give a few examples to show how this bill is inequitable and wrong in concept.

As a matter of fact, more than 54 percent of Kentucky's hospitals are facilities located in rural areas and are generally institutions of 100 beds or less. In all communities where a small hospital is located, the need for each such institution's licensed beds and scope of services has been carefully measured based on community requirements through the criteria of a strong state planning and certificate of need program, in effect since 1972, whose requirements are more restrictive than those issued by federal regulations. Even with rigid certificate of need requirements, some of these rural hospitals have been, from time to time, underutilized primarily because of a shortage of physicians in their communities. In reaction to these physician shortages, many communities have embarked upon active campaigns to recruit new physicians which, in turn, would make available basic health care services to their citizens in their own community. Consideration must be given to the cost to citizens of travel, lodging, loss of wages and being dislocated from their families during their illness when they cannot stay at home for their care. In many cases, the efforts to recruit and locate new physicians were led by hospital administrators with the active support of hospital boards of trustees and other concerned citizens. In a very large sense, the motivation for such activity was due to the known fact that it is less expensive to treat a patient locally for the majority of his care needs where the direct and indirect costs are lower rather than the cost of being referred to a major specialty treatment area in Kentucky's metropolitan centers. This concern related to the ability of local communities to provide and care for the basic and fundamental sort of illnesses in no way should be considered as an attempt by every local community to duplicate specialty and tertiary centers for the critically ill.

These activities as outlined above when they have been successful, would encounter the punitive provisions of the inpatient revenue limit and its admission load formula under S. 1391. Three such examples are as follows:

(1) Carroll County Memorial Hospital

Carroll County Memorial Hospital, located in Carrollton, Kentucky, is licensed to provide hospital services to more than 20,000 people through its 64 short-term acute care and 26 long-term care beds. Until very recently, however, the administrator of this hospital, E. Thomas DeHaven, was saddled with the responsibility of maintaining the financial stability of the hospital with only three physicians on the hospital's medical staff. Within the last seven months, two physicians were added to the medical staff at the hospital. As a direct result, the hospital's patient-days doubled! According to Mr. DeHaven, the monthly average patient-days before the two medical staff additions were 783 per month in contrast to a monthly average of 1,506 patient days after their admission to the staff. This amounts to a 52 percent increase in patient-days after the two physicians were added. These new physicians merely responded to existing community need which theretofore was not being met.

This situation though when viewed from the possible impact under the Hospital Cost Containment Act of 1977, is bad for the hospital because the bill would work

retroactively plus the fact that two or three additional physicians are scheduled to locate in Carroll County within the next 90 days. When these two new physicians arrive, Mr. DeHaven says he will be able to demonstrate, unquestionably, that some of his long-term care beds need to be converted to short-term acute care beds. Nevertheless, should S. 1391 become law, Carroll County Memorial Hospital would be under a "revenue cap" and with the limited availability of the exceptions process under the law, Mr. DeHaven says his community will be unfairly penalized for having planned and implemented the plan to increase the utilization and services provided by the hospital.

(2) Fort Logan Hospital

Another example of the same problem of how S. 1391 would adversely affect a small rural hospital which is attempting to increase utilization and expand services, is illustrated by recent events in Stanford, Kentucky, where the Fort Logan Hospital is located. Fort Logan Hospital, a 43 bed short-stay acute care hospital, whose administrator is Mr. Terry Powers, is experiencing growing pains caused by a variation of the Carroll County Memorial Hospital theme.

The community in Stanford acquired two new physicians almost two years ago which increased the medical staff by 40 percent. At about the same time the hospital secured a change in its bed classification to treat 8 of its 43 beds as obstetrics. Today, an additional change in intensity of services is also in progress in that a new four-bed special care unit permitting special observation of patients is being constructed. This will permit some local patients to stay home that were once being referred to other specialty treatment centers with no increase to the hospital's licensed beds.

The Board of Trustees of the Fort Logan Hospital are deeply concerned about how S. 1391 will affect their hospital and have gone on record as being opposed to it. Attached hereto as Exhibit 1 is a news story reflecting this opposition to S. 1391 for your review. Additionally, in terms of cost consciousness, the charge for a semi-private room at Fort Logan Hospital is a mere $38.00 per day.

(3) John Graves Ford Memorial Hospital

John Graves Ford Memorial Hospital in Georgetown, Kentucky, has the total backing of its community in its search for a solution to save the hospital. As the community leaders view S. 1391, it would virtually seal the demise of their local hospital. In order to fully appraise the members of this subcommittee to the particulars of that situation, there is attached hereto as Exhibit 2, a copy of a newspaper article on the Georgetown dilemma.

In conclusion, and in support of the American Hospital Association's statement that S. 1391 is unfair and unworkable, KHA must subscribe to an editorial appearing in the June 16, 1977, edition of the Berea Citizen, where it was said: "Congress and the Department of Health, Education and Welfare would serve the nation better by passing bills designed to strengthen and upgrade community hospital services, rather than deteriorate them." And as William Jennings Bryan said: "This is not a contest between persons. The humblest citizen in all the land, when clad in the armor of a righteous cause, is stronger than all the hosts of error". So is this cause of hospitals against the bureaucratic forces in HEW who want to thrust the burden of S. 1391 upon the American people. In the beginning of this statement, KHA said it sensed an improper motive in regard to the rationale and justification for this legislation. Kentuckians know what they have received from their community hospitals and of what they demand in respect to services. Once the patient-public is properly informed on this legislative proposal, KHA is confident that those educated patients will also support opposition to this bill simply because it threatens their local hospital's financial vitality, would ration services, and reduce the quality of care their hospital could provide its patients.

Advocate-Messenger
DANVILLE, KY.
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EXHIBIT 1

Fort Logan Opposes Hospital Cost Act

STANFORD (Spl.)—Fort Logan Hospital has gone on record as being against the Hospital Cost Containment Act of 1977, Terry Powers, administrator, said today.

In a meeting of the Fort Logan Hospital Board Tuesday night, Powers, Dr. C. Glen Click and Dickie Cooper reported on the Act which is now before Congress and should it be passed, it will regulate hospital revenue.

The Board decided to take action to obtain support of the local people in writing the congressmen and senators voicing their opposition to the Act.

Powers said should the Act be passed it will place undue hardship on the local hospital as well as others in Kentucky. He added that the Fort Logan Board feels that its hospital now has the lowest rates in the state and it strives to maintain the cost control.

Fort Logan Hospital Board also heard reports on the May 3 inspection of the new additions to the hospital and on the survey May 20 by the Joint Commission on Accreditation of Hospitals.

Powers said a group, which consisted of a physician, administrator and registered nurse, made the survey and will make recommendations to the Joint Commission for review. He said the local hospital will probably be notified of the results in about three months.

After the survey, the team held a summation conference with part of the staff and Powers said most of the recommendations were minor.

In making the building inspection May 3, Powers said a number of things have to be corrected on the new additions. He said workers began on the corrections Monday and they should be completed in about three to four weeks. Then another inspection will probably take place.

Construction of the two new additions on the east and west side of the present facility began in April 1976 and was scheduled to be completed by Dec. 28, 1976. However, the weather and other problems have delayed completion of the new critical care unit and offices, cafeteria and kitchen.

The Board will meet again on June 28.

EXHIBIT 2

News
GEORGETOWN, KY.
Circulation: 3,142

JUN 10 1977

First of series by local leaders

Hospital Cost Containment Act?

By Jane Allen Offutt

In the past few weeks we have read and heard a great deal about President Carter's "Hospital Cost Containment Act".

If this bill actually did contain costs and if the savings were passed along to the consumer, a great many of us would have cause to support the legislation.

As the bill now reads, we in Georgetown are in trouble. If this bill passes in its present unamended state there is no way we can keep John Graves Ford Memorial Hospital open!!

The first and most immediate problem with this legislation is that it limits hospital admissions. The base year used for figuring how many admissions a hospital can have is 1976. That was one of our worst years here in Georgetown. We were experiencing a decreasing number of primary care physicians and a rapidly expanding population. Now with two new physicians coming in September and with the University of Kentucky's Residency Program due to begin in 1978, our admissions will be limited to the percentage of occupancy we had in 1976!

If a hospital can only admit a limited number of patients, who will not get admitted? The indigent patient. The one who can not pay the bill will suffer. This is the irony in President Carter's support of this bill. His whole political platform was to take care of the low income people. If this is a sample of how he plans to take care of them, what type of society are we facing?

In actuality, we probably won't have to be concerned about the U.K. Residency Program because U.K. will not be allowed the capital expenditures to finance its proposed satellite program. U.K. also will have to cut down if not eliminate admissions of indigent persons.

You may now be asking yourself, "How does this kind of legislation get as far as it has?" "Where are the people we elected to represent us in Washington?" At present, I do not know where Congressman Breckinridge, Senator Ford and Senator Huddleston stand on this issue. I do know that Senator Kennedy had a great hand in drafting the Senate Bill 1391. Now I can understand Senator Kennedy's interest. I am sure the hospitals he and his family frequent could cut costs. I also know that Boston is one of the major medical centers of our Country. I am sure the "country club" atmosphere of many of these health care institutions create scandalous costs. In Kentucky, however, health care costs are 27% lower for inpatient day care than the national average. Do we get rewarded for such performance? The answer is, "No." What we do get is people in our community dying because the Federal Government is controlling hospital admissions.

In December of 1976, the people in Scott County voted an ad valorem property tax on themselves as a means for keeping our hospital liquid. The Community Health Expansion Committee had been hard at work

recruiting physicians for Georgetown. Now when it looks as though all will be well we have to rise to another "cause". Everyone must accept this responsi-



bility. If you sit back and let a few fight this battle, it will be lost. There is something we can do. We must each sit down and write three letters. Write to Congressman John Breckinridge, Senator Walter Huddleston, Senator Wendell Ford. Let them know that you will not sit still and let the Federal Government decide who among us will live. The only way we will get action

is to mail thousands of letters to Washington and appl political pressure. We are all busy and our lives ar complicated, but it only takes a minute to write a lette I would hate to carry the guilt of my child's deat because we had lost our hospital and the Lexingto hospitals had reached their federal governme limitation for admissions, and I did not have time t write a letter.

Remember Jimmy Carter's promise, "to listen to th little guy." Write him. Maybe he will listen. Address The President, The White House, Washington, D.C Dear Mr. Carter.

If you have reservations about how to write any these letters, come to the County Court House Monday, June 27, Tuesday June 28, Thursday, Ju 30, and Friday, July 1, The Hospital Auxiliary will there with pens, stationary and assistance from 9: a.m. to 12:00 and from 1:00 to 4:00 p.m. If you car make that and you need assistance, call the loc Hospital, 863-2141.

The Addresses of our Congressman and Senators a in this paper and also some tips on writing to them. I sure to refer to H.B. 6575 or S.B. 1391.

Let's unite in Scott County and show Preside Carter what the "little guys" can do!!!

[Reader Comment Welcome]

LEGISLATURE OF MICHIGAN
WASHINGTON OFFICE
444 North Capitol Street, Suite 214
Washington, D.C. 20001
202/624-5490

May 9, 1977

MEMORANDUM

To : Pamela Paul-Shaheen

From: Herb Robbins

Subj: Practical reasons for supporting the Administration's hospital cost containment proposal

You have asked me to reduce my arguments for support of H.R. 6575 to writing prior to your briefing the Speaker and the Senate Majority Leader. Since you and Rick Curtis have done a thorough, and as I read it, generally favorable analysis of President Carter's hospital cost containment proposal, the decision to support, oppose or remain neutral may be decided on philosophical, political, or practical considerations. It is not my function or intention to argue philosophy or politics, but rather to suggest some pragmatic reasons why the State should favor the general approach of the Carter proposal.

1. The State is already doing the same thing with respect to the Medicaid program.

The Michigan limitation on reimbursement of hospitals for Medicaid patients has been in effect for a year and is very similar to the program proposed for all hospital reimbursements by third party payors and individuals. For the State to insist on restraining Medicaid costs while the rest of the costs grow faster must ultimately lead to a shifting of costs to non-Medicaid patients, a desire by hospitals to reduce or eliminate admissions of Medicaid patients in favor of patients who will pay higher rates, or a reduction in intensity of care for Medicaid patients so apparent as to be intolerable. Thus, having taken the initiative in the Medicaid program, Michigan needs overall revenue restraints on hospitals or there may be a real crisis in Medicaid in the near future.

2. There are four alternatives, which when considered, points to support of the Carter initiative as the best course to take.

   a. A State can do nothing and watch medical costs continue to escalate unless some unknown factor relieves the inflationary pressure. It should be pointed out that hospital costs are escalating far more rapidly than other sectors of the economy and that most experts say there is no operative market mechanism to bring hospital costs under control.

b. A State can undertake to set hospital rates for all third party payors as six States have done. New York's rate-setting law is being challenged in court, but it is likely that States can undertake programs that legally and effectively restrain revenues of hospitals.

c. A State might be able to come up with an alternative plan for the Federal government to restrain the rate in growth of hospital revenues. There may be a better way, but it is unlikely that the Administration, having come this far on its approach, will support an alternative approach. If an alternative approach is ultimately adopted, it will be because of pressure from providers.

d. A State can support the Administration's approach -- probably with some recommendations for improvements. The program appears to have a reasonable likelihood of restraining hospital cost growth according to the experts in the State legislature and executive departments; it has the support of the AFL-CIO and UAW; the National Conference of State Legislatures and National Governors Conference appear to be prepared to give the plan qualified support, and the Carter administration seems committed to its proposal.

3. To leave each State to its own devices in restraining the rate of growth in hospital costs penalizes States like Michigan that are willing to attempt contraints.

This argument is especially well founded in the Medicaid and Medicare programs where large outlays of Federal dollars are involved. From a very selfish viewpoint we will only exacerbate our standing as a donor State for Federal outlays if we control hospital revenues and therefore demands on Federal dollars while other States do not. Furthermore, when the time comes that the pressures on Federal dollars are too great to ignore the restraints will most likely lock in revenue levels in existance (as done by the present Carter proposal) and those States that took the lead will hurt their hospitals more than those States that let hospital revenues inflate unchecked.

4. But why not be neutral?

a. This is the single most important health and welfare proposal likely to be acted on by the Federal government this year and probably next. Without some restraint on hospital costs, the Federal government can't begin to develop an effective health care proposal and regardless of how restrictive a welfare reform proposal, there will be no real relief for States. The whole human resources endeavor at the Federal and State level is being drained by spiraling medical costs. There simply won't be any money to improve other needed support and service programs without some restraint on medical costs.

b. Hospitals can't contain costs by themselves. There is no effective market mechanism since most individuals who get hospital care are covered through health insurance of some

kind and therefore have no incentive to restrain costs.

c. One of the arguments against the Carter proposal is that it is regulation of an industry. It should be understood that it is not like an industry subjected to market-place pressures and economic factors. The financing system even avoids the pressure of the tax system. Furthermore, the Carter proposal is not regulation, but an overall restraint, which hospitals, States and third party payors can meet by methods and means short of regulation or rate-setting.

d. States need this type of federal restraint on hospitals so that State actions to restrain Medicaid costs, limit unnecessary expansion, and achieve realistic adjustments in the health care delivery system can be successful.

HEALTH DELIVERY COST CONTROL

by

Leon C. Hamrick, M.D.

The costs of health care are rising more rapidly today than at any time in our nation's history; and a brief review of these costs will hopefully add perspective to our overall discussion today.

Our national health expenditures during fiscal year 1976 reached $139.3 billions of dollars. This 1976 total represented a 14% increase over the estimate of $122.1 billion dollars in fiscal year 1975. When considering the total increase during the preceding year with this past fiscal year, costs have risen by $33 billion dollars or 31%. In comparison, the economy in general has grown at a slower pace of 18% over these same two years.

When looking at per capita expenditures or at the gross national product we again see the same trends. In 1970 the per capita expenditure for health care costs was $334 compared to $628 in 1976. In 1965, 5.9% of the gross national product was spent for health care costs, in 1970, 7.2%, and in 1976, 8.6%.

A closer look at where health care dollars are spent, using 1976 figures, shows the following break down:

Hospitals	$55.4 billion	39.8%
Physicians	$26.4 billion	19.0%
Drugs	$11.2 billion	8.0%
Nursing Homes	$10.6 billion	7.6%
Dentists	$ 8.6 billion	6.2%
Research & Construction	$ 8.3 billion	6.0%
Other costs	$18.8 billion	13.5%

LEON C. HAMRICK, M.D. - Chairman, Board of Censors, State of Alabama; Chairman, Alabama State Committee of Public Health; practicing surgeon and medical director of Lloyd Noland Hospital and Clinic, Fairfield, Alabama.

PROBLEMS AND TRENDS INFLUENCING INCREASE IN COST

A first in trying to come to grips with the problem is to identify problems and trends that have contributed to the rising costs.

Many thoughts and ideas have been expressed by many sources and in many ways on this particular aspect with emphasis often as not being colored by one's interest--be he or she "provider," consumer, insurer, business or governmental sponsor, newsman, etc.

While not attempting to cover these strictly in order of impact, discussion of a number of these is in order.

1. Technological Advances - Advances in diagnostic and treatment procedures have had considerable impact on both health care costs and on prevention of deaths attributable to major killers such as heart disease, cancer, stroke and kidney disease. Heavy sums have been and are being expended to the extent that quality of life is improved and maintained while the life span itself is being lengthened.

2. Increasing Staff/Patient Ratio - This is impacted by the above described technological advances and by improvement in the quality of staffing selected services such as coronary and intensive care units, renal dialysis units, full time physician coverage in emergency rooms, and many other services now available which were not a short time ago, increased staff has also resulted from increasing regulatory requirements for nursing and other services in hospitals and nursing homes.

3. Reporting Requirements and Standards - Added paperwork and adherence to strict governmental reporting requirements contribute to the overall rise in health care costs, particularly with the growing number of Medicare and Medicaid patients. When looking at the number of copies of patient records reproduced and transmitted from my own hospital, I shudder to think of the volume country wide!

   There is much too much overlapping of regulations and regulatory requirements for health care institutions. This often causes administrative nightmares and budgetary strain.

4. Physical Plant Requirements for Comfort and Safety - Many ideal and even utopian ideas concerning safety have crept into mandatory regulations pushing costs inordinately higher in order to come into compliance.

An example of this is the proposed requirement that low voltage wires be carried through conduits in hospitals in spite of the fact that there has never been a fatality from contact of these low voltage wires. Twenty-five years ago, none of the three hospitals that I trained in could boast of air conditioning even in the surgical suites. So when you start comparing costs of 1950 to today, the cost of machine and power has to be taken into consideration as well.

5. Unnecessary Services - The demand for and provision of unnecessary services during hospitalization, such as color television, bedside phones, special select foods, etc., add to the comfort and enjoyment of the patient; but they also add to the cost of hospitalization.

6. Liability Insurance Cost - A three hundred per cent jump in costs from 1975 to 1976 was common for Alabama hospitals, and reports of up to a 1,000% increase in other areas of the country for the same period has been noted. Costs to physicians over the past two years parallel this experience.

7. Inappropriate Use of Health Care Resources - Inappropriate use of resources by patients and physicians together in order to obtain third-party coverage of testing, or custodial care of particularly the elderly who could otherwise be cared for in the home are abuses worthy of consideration.

8. Demographic Changes - Population changes exert no little effect on health care cost and with each year exert more. Our country is not only becoming more populous, people are living longer; older people have more health problems and require more and longer institutional care. The oldest 10 per cent of the population accounts for more than 33 per cent of inpatient hospital days.

9. Government Health Care Programs - The availability of Medicare, Medicaid, and other federally subsidized programs contribute enormously to health care cost. This is not to say they are not needed or justified, but merely reflects that if coverage was not available, people would go lacking for care and the total cost would be substantially less. A brief look at the people covered would indicate they fall in a group whose problems number more and whose overall cost for care is probably greater than for the population as a whole.

10. Broader Benefits and Wider Eligibility - Insurance now pays ninety per cent of hospital bills, and sixty-five per cent of physician care expense. Twenty-five years ago the patient paid two-thirds of his medical expense. Without saying this is good or bad, one would have to agree that health insurance has at least modified the restraint of the beneficiary in seeking health care, particularly in those programs in which the beneficiary does not contribute to the cost of insurance.

11. Fraud and Cheating - Without doubt this exists. You all have read or know of instances where this has occurred; while this is not the culprit accounting for the bulk of increased health care cost, it should not be ignored. Overutilization, whether it be instigated by provider or consumer, and while technically not illegal, accounts for far more unnecessary cost than out-and-out fraud.

12. Inflation - General inflation in goods, services, and labor has its impact on health cost care just as it does on the general economy. The field of health care is probably more vulnerable to inflation in the area of ever increasing technology and demands and because it is labor intensive; yet it presently compares favorably to other fields in such areas as labor costs. However, 10 years ago and in subsquent years after coming under minimum wage standards, hospitals did have significant "catching up" to accomplish.

COST CONTAINMENT

Now that we have explored some of the problem areas contributing to increased health care costs, let us turn to areas in which we may find opportunities for cost containment.

1. Cooperativeness - First of all, I believe it is imperative that all of us--physicians and other health care personnel, institutions, consumers, insurers, and government--stop blaming each other; indeed all of us as a part of our social, environmental and physical makeup are responsible to some degree for the escalation of health care costs, and it's time we accepted this and turned to working out solutions.

2. Priority Setting - Now if we are going to accept, or be forced into, limiting health care costs, our decisions must be based on setting priorities so that our budgeted dollars will accomplish the greatest good; and in pursuit of this somewhere along the line tough questions including those affecting

the quality of existence of some or the shelving of life saving innovations for others until they are cost effective may have to be faced by the health care provider and the public.

3. Preventive Measures - Health education without doubt is one of the cheapest and could be one of the most effective measures in prevention of disease and infirmity.

   Patient and public education with efforts at preventing or minimizing illness and injury even to the extent of involving steps toward fundamental changes in living practices would most certainly have an impact on health status and thus in reducing health care costs. One needs only to look at the problems caused by alcoholism, smoking, poor diet, accidents at home, work, and in motor vehicles, and violence committed on others, to see where great dividends are possible. This merely scratches the surface. Areas such as family and perinatal counselling, genetic screening, better self care in chronic disease and many other areas need addressing; and much of the educational process needs to be begun early in one's life and general educational experience. Other levels on the ladder of prevention affecting health care costs are immunization, early diagnosis and treatment, disability limitations, and rehabilitation.

   Someone is falling short when in this enlightened country of ours there are eighteen million children who have not received polio protection and fifteen and one-half million who haven't even been immunized with DPT, the most commonly used immunizing agent, against diphtheria, whooping cough, and tetanus. I must say in Alabama we are doing a more creditable job since the passage of the pre-school immunization statutes.

4. Cooperative or Merging Services - Not every hospital needs an open heart suite, a cobalt unit, a linear accelerator, or computerized scanner. Highly specialized care, such as these examples, should be limited to given institutions in order that utilization may approach economic reasonableness. Just to keep up with the Joneses or the fear that someone may get ahead of you, should not be justification for unneeded expansion or duplication of services.

5. Utilization Review and Professional Standards - Much concern has been wafted over these areas. I would have to agree that they are intrusions on the

patient, the physician, and the institution and the thought that they are needed is obnoxious. However, it is my contention that if a conscientious job is both rendered and accepted, this sacrifice to the fiddler can be tolerated. Hopefully, out of these measures, patient and provider at the grass roots level can be shown, at significant economic savings, that cost can be lowered by eliminating unnecessary admission (to both short and long term care institutions), excessive stay, and improper use or abuse of therapeutic and diagnostic services without reducing the quality of care.

6. Liability Insurance Cost - Debate in this area has been heard long and loud in hospital corridors and lounges, physicians and insurance company offices and meeting places, from members of the Bar, and in legislative halls. Gains have been made in tort changes, ever so grudgingly, without adversely affecting the bona fide claimant; yet there is room and need for more change when rates for insurance have soared in Alabama to $500 per hospital bed per year and to $7,000 annually for an orthopedic surgeon or obstetrician and in many other areas of the country tripled and quadrupled, and even higher than these figures. These are health care cost items and as such are in finality passed on to the person paying the bill for health care.

   Above all, there needs to be a common understanding that medicine and surgery is not always an exact science, and there are no guarantees that living tissue will react in the same way or produce the same result one hundred per cent of the time.

   Defensive medicine practiced from conscious or subconscious fear that something might possibly be overlooked and later fuel a liability claim has undoubtedly led to increase usage of diagnostic and professional time at no little cost. As long as the liability climate remains as it is, this problem will be most difficult to address and will continue to add to increasing health care cost.

7. Insurance Eligibility and Benefits - Ways at overall better and more economic utilization of benefits could result in measurable cost containment. Coverage of cost saving payments such as service done as an outpatient and acceptability by hospitals of preadmission diagnostic work done in physicians' offices or other x-ray and laboratory facilities could avoid duplication of studies and costs.

Judicious and proper use of health care benefits in a cooperative way by both patient and provider can help hold down cost. The closer everyone watches health care dollars, the less increase one (or his employer) may have to pay for coverage. In this day of incentive, study of reward for such judicious use of benefits by the recipient might be of merit just as incentive to providers to hold down cost is being considered.

8. Governmental Programs - Rewriting of the statutes to cut back on services, set limitations on expenditures, refine and reduce costly regulatory requirements and reporting, elimination of inconsistent effects on the providers, and provisions of some fair co-payment or scaled responsibility mechanism

Something is out of kilter in our Alabama society, when we see in the Medicaid program that forty-three per cent of the $185 million dollar budget is spent on nursing home care and that eighty per cent of our nursing home beds are occupied by Medicaid patients whose entire total make up but ten per cent of the state's population. One can't help but suspect that availability without consumer restraint must be a factor in the imbalance.

While discussing governmental programs, we might suggest that federal hospitals also be involved in cost containment measures and approaches in the areas that other public and private hospitals are addressing and being addressed. An exchange of information, ideas, and methodologies might well be fruitful.

9. Alternative Means of Health Care Delivery - Alternative ways of delivering health care should be studied, yet approached with care. New ways should have avenues for trial, but we must guard against interference with basic quality. Economic and medical impact evaluation should be done before enactment of new programs, just as new, or changes in, regulatory requirements should have the evaluation.

10. Institutional Measures - Reduction in operating and construction costs through improvement of facility design, construction practices, ongoing evaluation of staffing needs, assessment of employee productivity, procedures, and routines have and can measurably and favorably affect cost.

11. Prospective Reimbursement - This has been proposed as one method of cost containment. Because of complex problems in forecasting costs in which hospitals

have no control, across the board implementation of this measure would present much difficulty in implementing. Certainly, institutions should not object to continuation of experimental projects involving prospective incentive reimbursement methodologies until determination can be made of the fairness and value of them.

It was most interesting to see how the dialogue went in the discussion groups, with participant interest certainly being governed by background and profession. Mr. Thrasher, of Blue Cross Blue-Shield made one point not made before, concerning a recent survey on health care spending. Fifty-six per cent of those queried did not think enough was being spent on health care, and only 6 per cent held the contrary view that too much was being spent. He also told of ongoing research and applications of renovations of the more economic utilization of benefits.

A gentleman from Tuskegee made the point that more health care in rural areas should receive first priority. Education, incentives to provider and patient, and alternatives to institutional care, such as home health care, were universally expressed as avenues to explore over the long haul of cost containment.

The point was also made that under-utilization could lead eventually to increased cost. Lack of inclusion, inadequate amounts of such studies, as in public health and preventive medicine, and economics in medical school, manpower distribution, and the possibility of overkill in numbers of trained personnel, several years down the line, were listed as areas of concern. Insufficient research in areas leading to cost containment, and clinical applications, particularly in equipment and supplies, likewise, was mentioned.

Mr. Dawson referred to several programs being carried out by the Veterans Administration, such as community service programs, which is a program designed to reach veterans with chronic disease, and their families, to try to prevent hospitalization; also, the reality orientation for geriatric patients, getting them back in the homes, and out of long-term facilities, and the rehabilitation program for alcoholics. Perhaps we would do well to look at these more closely. Over all, I believe everyone enjoyed participating, and having a background mix was quite helpful.

In summary we have looked at the problem of health care cost, at problems and trends affecting the escalation of these costs, and some of the ways in which we can address the problem. Yet in reality the real crux of the matter of cost will ultimately depend upon the needs, expectations, and demands of the public and how far the individual, employer, and government will go in paying for each of these.

STATEMENT OF THE MARYLAND HOSPITAL ASSOCIATION
TO THE SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH
OF THE SENATE COMMITTEE ON HUMAN RESOURCES
ON S. 1391, THE HOSPITAL COST CONTAINMENT ACT OF 1977

THE MARYLAND HOSPITAL ASSOCIATION IS AN ALLIANCE OF 60 GENERAL, SPECIAL AND GOVERNMENTAL HOSPITALS IN THE STATE OF MARYLAND. AFTER THOROUGH REVIEW OF THE HOSPITAL COST CONTAINMENT ACT OF 1977 WE FIND IT IS APPROPRIATE TO SUBMIT COMMENTS. WE APPRECIATE YOUR PERMITTING THE RECORD TO REMAIN OPEN AFTER THE HEARINGS IN ORDER TO RECEIVE WRITTEN STATEMENTS SUCH AS OURS.

S. 1391 IS FUNDAMENTALLY UNSOUND IN CONCEPT AND DISCRIMINATORY IN DESIGN. THE DETRIMENTAL EFFECTS OF IMPOSING ARBITRARY CAPS ON SELECTED SEGMENTS OF THE ECONOMY WERE WELL DOCUMENTED UNDER PHASE IV OF THE ECONOMIC STABILIZATION PROGRAM. SINGLING OUT CERTAIN INDUSTRIES CRIPPLES THOSE GROUPS' ABILITY TO COMPETE IN THE MARKETPLACE FOR MANPOWER, GOODS AND SERVICES, AND SCARCE CAPITAL FUNDS. AS SOON AS THE CONTROLS ARE LIFTED, THE PRICES FOR THOSE INDUSTRIES RISE AT AN APPALLING RATE FOR A "CATCH-UP" PERIOD. THE OPPOSITE OF STABILIZATION -- CHAOS -- RESULTS.

ONE MAY POINT TO THE EXCEPTION FOR NONSUPERVISORY PERSONNEL WAGE INCREASES AS A MEANS TO MITIGATE THE IMPACT OF THE ARBITRARY CAP. HOWEVER, THE REAL IMPACT OF SUCH A MANEUVER IS INTERNAL STRIFE AS WAGE AND SALARY STRATA ARE TURNED TOPSY-TURVY. IN REALITY, THE FEDERAL GOVERNMENT IS DISCRIMINATING AGAINST ONE GROUP OF EMPLOYEES AND FAVORING ANOTHER. WAGE AND SALARY INFORMATION DEVELOPED BY MARYLAND'S HEALTH SERVICES COST REVIEW COMMISSION DEMONSTRATES THAT MARYLAND HOSPITALS CURRENTLY PAY UNSKILLED EMPLOYEES HIGHER RATES THAN INDUSTRY PAYS FOR COMPARABLE JOBS. JUST THE REVERSE IS TRUE FOR SKILLED LABOR PAY SCALES. THE PASS THROUGH PROVISION WILL ONLY AGGREVATE THE SITUATION.

CONCEIVABLY SINCE MARYLAND HAS AN ESTABLISHED RATE CONTROL PROGRAM WITH AN EFFECTIVE TRACK RECORD, IT WOULD BE IN A POSITION TO OBTAIN A WAIVER FROM TITLE I OF THE PROPOSED LEGISLATION. THE LANGUAGE UNDER SECTION 117 REQUIRES HOSPITALS IN THOSE STATES WITH WAIVERS TO MEET MORE STRINGENT REQUIREMENTS THAN THOSE SUBJECT TO THE ACROSS THE BOARD ARBITRARY LIMITATIONS. THE WORDING OF SECTION 117 ACTUALLY PROVIDES A DISINCENTIVE FOR HOSPITALS OR STATE GOVERNMENT TO QUALIFY FOR AN EXEMPTION.

WE ARE FIRMLY CONVINCED THAT A STATE LEVEL RATE CONTROL PROGRAM IS THE SOUNDEST ALTERNATIVE FOR CONTROLLING HOSPITAL COSTS. A SIMPLE REVENUE CAP APPROACH TOTALLY DISREGARDS THE COSTS INVOLVED IN PROVIDING SERVICES. AND FURTHER, EXPERIENCE UNDER MEDICARE HAS DEMONSTRATED THAT A NATIONAL SYSTEM BASED UPON A STANDARDIZED FORMULA CANNOT BE SENSITIVE TO LOCAL NEEDS. GIVEN TODAY'S DISTRIBUTION OF HOSPITAL RESOURCES, IT IS A BASIC FACT THAT SOME AREAS OR HOSPITALS NEED MORE, WHILE OTHERS CAN SURVIVE WITH LESS. IT IS ALSO QUITE BASIC THAT ONE CANNOT REALISTICALLY MANDATE A LEVEL OF SERVICES -- AS THE GOVERNMENT DOES UNDER THE MEDICARE AND MEDICAID PROGRAM -- WITHOUT TAKING INTO ACCOUNT THE COSTS FOR GENERATING THOSE SERVICES. THE STATE RATE REVIEW PROGRAM OPERATING IN MARYLAND HAS THE ABILITY TO MAKE THE NECESSARY RESOURCE ALLOCATIONS AND TO GIVE APPROPRIATE CONSIDERATION TO THE INPUT COSTS -- THE FORMULAIC SYSTEM OF THE COST CONTAINMENT ACT DOES NOT.

WE WOULD BE HAPPY TO ANSWER ANY QUESTIONS YOU MAY HAVE.

Testimony on the Hospital Cost Containment Act of 1977 HR. 6575

Jonathan Fielding, Commissioner

Department of Public Health

Commonwealth of Massachusetts

11 May 1977

My name is Jonathan Fielding. I am the Commissioner of Public Health in the Commonwealth of Massachusetts. I appreciate the opportunity to testify before the Committee.

The Commonwealth of Massachusetts is strongly supportive of the intentions of the Hospital Cost Containment Act of 1977 and the placement of limits on hospital revenues and capital expenditures. Such a proposal is overdue and we feel enactment this year is essential.

We do have some specific concerns about the proposal in terms of the intensity of state involvement and important next steps.

At the outset, I wish to note that Massachusetts is one of the few states that has programs in place of planning, certificate of need and rate regulation. Our experience has taught us that cost containment can be most effective and equitable where there are ties among planning, rate regulation and capital expenditures controls.

In designing a cost control system, consideration needs to be given to providing incentives as well as disincentives to hospitals to control costs, while at the same time assuring that the kinds of services needed by the public are available. Unfortunately, the proposed legislation may lead hospitals to shift their mix of services in ways that are not desirable. For example:

1. A hospital might try to avoid admitting patients likely to stay longer or need more services by virtue of their diagnosis, age, or lack of support to recuperate after discharge. Section 126 of the proposal provides a mechanism for investigating complaints on a case-by-case basis. A more systematic treatment of this issue must await a second phase, by providing other means for controlling revenues than by admission. This can be done through the analysis of case mix data and careful scrutiny by state agencies and Health System Agencies.

2. The hospital is rewarded more for two short admissions than one long one. Someone who has a diagnostic work-up and is determined to need surgery might be discharged and quickly readmitted. This could be alleviated by modifying the definition of admissions to exclude patients who have been inpatients in the same facility within seven days prior to the date of admission.

3. Hospitals may admit more patients for simple, diagnostic work-ups, because the volume adjustment is based on admissions, without regard to procedure or diagnosis. A data base is essential to effectively deal with this issue so that unnecessary volume changes for diagnostic work-ups could be identified. This also provides an example of the need to provide for the involvement of professional standards review organizations.

4. Hospitals may be encouraged to move (as noted under Section 126, "Improper Changes in Admission Practices") away from serving patients covered by Medicaid or Medicare which could discriminate against the poor and the elderly in particular. Under Section 126,

HSAs would make a finding as to any hospital accused of shifting admissions. The responsibility for making the finding should be shared with state government which has a strong interest in assuring that there are no inequities in the regulation of health services throughout the state.

At present, the only sanction available against a hospital which changed its admission practices so as to reduce the proportion of inpatients for whom reimbursement is less than inpatient charges, is potential exclusion from the program established by Titles V, XVIII, and XIX of the Social Security Act. This exclusion may be enforced at the discretion of the Secretary. Since such an exclusion would create extreme hardship on the hospital, as well as on patients dependent on that facility and those programs for their routine health care, enforcement of this provision might be difficult or even counterproductive. Consideration should be given to graduated sanction that would affect the hospital and not the patients.

The linkages between P.L. 93-641 and the Hospital Cost Containment proposal must be strenghtened specifically in relation to the requirements for:

(1)-State Medical Facilities Plans and State Health Plans that will show future allocations of facilities and services

(2)-Appropriateness reviews and findings for all institutional services

(3)-Certificate of Need activities for review of capital expenditures

For example, the State Medical Facilities Plan, intended to be a plan of all hospitals and then services in a state, should be the basis for exceptions under the capital expenditures side of the proposed legislation. The Bureau of Health Planning and Resources Development has not, to date, released regulations on these plans. Regulations should be promulgated quickly and additional resources made available so that states can rapidly develop these plans.

Reviews of the appropriateness of existing institutional services are required of both Health Systems Agencies and State Health Planning and Development Agencies. Inappropriate services or institutions should become ineligible for reimbursement under any Federal program. Criteria and standards for the appropriate capacity and utilization must be developed as rapidly as possible around high cost services and overutilized services ranging from CAT Scanners and open heart surgery to inhalation therapy and routine blood tests.

In Massachusetts, we have gone through this process in the acute care sector and found that there are 6,600 unnecessary beds out of a total of 26,778 beds. This reduction would move us from a present ratio of 4.6 beds per 1,000 population to 3.6 beds per 1,000 population.

In addition to the amendments of the certificate of need program presently in the proposed legislation, consideration should be given to directly linking approval of certificate of need requests to conformity with a State Medical Facilities Plan approved by the Secretary. In addition, the current proposal should be modified to drastically reduce the circumstances where new beds can be approved if the ratio of beds to population exceeds 4.0 beds per 1,000 population.

These recommendations would force states to consider the proper allocation of hospital resources in the future and to base the present decisions on a clear master plan which has HEW approval.

For the proposed system to work, both initially and in the future, we need uniform information from hospitals on their volumes and types of services and case mix. Comparisons across institutions will alert us to gross inequities or possible over or under utilization. Better information is especially needed for ancillary services, a major element of cost increases in recent years.

Consideration should be given to expanding the scope of the cost containment proposal after the interim phase to include long term care and outpatient services. Although costs for these sectors may not be as volatile as inpatient hospital services, recent increases in these areas have been very substantial and may be further spurred by the limitation on inpatient revenues. As in the hospital inpatient sector controls should link planning, capital expenditures, rate setting and utilization review.

Due to administrative necessity, the Act allows the same percentage increase to all hospitals regardless of whether they are efficient or inefficient during their base accounting year. This tends to perpetuate existing inefficiencies and should be changed after the interim phase. Operational means to distinguish inefficient and efficient hospitals are not yet available. Changes to this Act should allow hospitals to be treated differently in terms of increases of total revenue; their allocation should depend on their efficiency, the relative needs for their services, and how they fit into the approved State Medical Facilities Plan. These decisions can best be made at the state level.

We strongly recommend continued support and expansion of state rate setting experiments, planning initiatives in the development of standards for different services, and technical assistance to build state capacity.

One major deficiency in the current proposal is the exclusion of Federal hospitals. This exclusion prevents a careful review of the appropriateness and efficiency of these facilities and removes them from the responsibility of cooperative planning with other institutions and public agencies in the state and the region.

My testimony suggests that additional responsibilities be given to state and local agencies. Additional responsibilities require additional resources. This is particularly true if states are to improve the capability to deal with the complex financial and logistical requirements which this proposal sets out.

In closing, I want to stress that the Commonwealth of Massachusetts strongly supports the intentions of the Act and feels enactment this year would be a giant step forward and a necessary underpinning for any national health care financing system.

I would be pleased to respond to any questions.

THE MEDICAL COLLEGE OF PENNSYLVANIA

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OFFICE OF THE PRESIDENT

May 16, 1977

MEMO TO: Dr. Stuart Shapiro
Professional Staff
Senate Health Sub Committee

FROM: Jeanne D. Brugger, President
Medical College of Pennsylvania

RE: S.1391

The following comments provide some background information on the Medical College of Pennsylvania and the negative impact that some of the provisions of S.1391 would have on our institution.

The Hospital of the Medical College of Pennsylvania is a 329-bed medical school hospital located in the northwest section of Philadelphia. We provide a wide range of medical services to patients from our predominantly low-income neighborhood, as well as from other parts of the city and its suburbs. By utilizing sound management techniques and innovative financial approaches, we have been able to maintain our financial status and break even, after allowing for depreciation expenses. We are proud that we have accomplished this while maintaining the lowest costs and length of stay of the five medical school hospitals in Philadelphia. The impact of S.1391 on institutions like ours, which provide a large amount of free care, is potentially disastrous.

A large proportion of our patients are on the Medical Assistance Program. These patients use our clinics and emergency room extensively (almost 90,000 patient visits in FY 76). As a result, the vast majority of services in our out-patient area, which accounts for $4 million of our $20 million budget, are paid for by Medical Assistance. Pennsylvania Medical Assistance reimburses hospitals a flat $9 per out-patient visit, regardless of the treatment provided. Since our costs are approximately $22 per visit, we thereby experience substantial losses in providing these services to the people in our community, many of whom are completely dependent upon us for their health care.

Unlike other states, Pennsylvania's reimbursement for out-patient care under Medical Assistance is not related to reasonable costs, percentage of charges, or any other objective criteria. Instead, the amount is arbitrarily fixed by the State Legislature and often

remains at the same level for several years. Since our costs for labor and supplies continue to increase for out-patient as well as in-patient care, we must cover our losses somehow in order to remain solvent. We have had no alternative but to raise in-patient charges significantly so that we can recapture these losses from the 12 percent of our in-patients who pay charges. We are reimbursed on a cost basis for those 83 percent of our in-patients covered by Medicare, Medicaid, and Blue Cross; the other five percent of our in-patients pay nothing. Unlike most other such plans, Blue Cross of Greater Philadelphia reimburses hospitals only for costs related to in-patient care. Because of these various reimbursement mechanisms, a 9% increase in costs and in charges would result in only a 6.9% increase in revenue. Sections 102 and 111 of S.1391 provide that increases in total revenue for in-patients in each separate payment category may not exceed the ceiling based upon the GNP deflator. Since we would not be able to increase charges for in-patients, an increase of nine percent in our out-patient costs would result in an additional deficit of $360,000 (9% of $4 million). Under S.1391 we would have no alternatives to recoup these losses. We point these examples out since the same situation would not pertain to hospitals in other states in which hospitals are reimbursed on a cost basis for providing out-patient services.

As mentioned above, five percent of our in-patients are classified as medically indigent; they have little income but, for various reasons, do not qualify for Medical Assistance. These patients are incapable of paying their hospital bills. Since the costs attributable to these patients approximate $1 million, a nine percent increase would translate into a further deficit of $90,000. Again under S.1391, we would be unable to increase our charges, as we have in the past, to recover these losses from those patients from whom we receive charges. Since we completely endorse the concept behind Section 126, which expressly forbids a change in admission practices to reduce free care, we see no way of avoiding this additional financial burden.

As drafted, S.1391 would have another inequitable impact on our institution. As mentioned above, our cost and length of stay are lower than at other Philadelphia medical school hospitals. In addition, due to excellent utilization review methods and cost containment practices, our cost per admission is approximately 25 percent below these other hospitals. Under S.1391, these other institutions would be allowed higher increases in absolute dollars, thereby penalizing us for our prudent financial management.

Another area of concern is Section 114. Under the terms of this section, the "base accounting year" is defined as the accounting year which ended in 1976. Although adjustments could be made for the intervening time period, these could not exceed certain predefined standards. It is highly likely, in fact, that institutions such as ours could actually prove to be out of compliance for the past ten months, due to rate increases implemented prior to the development of the Bill.

A further problem faced by many hospitals, and in particular medical school hospitals, concerns the use of the GNP "deflator" in the calculation of the ceiling. This is the case despite the fact that an adjustment would be made equal to one-third of the difference between average hospital increases over the past two years and the "deflator." As a medical school hospital, we incur many expenses which would not necessarily be taken into account by this formula. One which comes readily to mind is the premium for malpractice insurance for full-time salaried faculty. This increased from $70,000 in FY 75 to $1.2 million in FY 76 - an increase of 1400 percent. Obviously, no standard measurement of inflation, whether a hospital index or not, could ever reflect an increase of this magnitude. Yet this expenditure is now a very large part of our costs, increasing in one year from one-half of one percent of our budget to over six percent.

The specific regulation in Section 124, which deals with the exemption of non-supervisory personnel wage increases, is also a potential problem area. The attempt to exclude lower paid, non-supervisory employees from the cost ceiling is commendable but unrealistic - at least at our institution. Many of our employees are represented by the National Union of Hospital and Nursing Home Employees and, as such, have been receiving rather sizeable increases in wages. The existing contract with this union expires on June 30 of this year and their current demands call for increases of .75 an hour or 13%, whichever is greater. Hopefully, the final settlement will be considerably less than this amount. Nevertheless, our wage scales, like those in most large industrial organizations, are designed so that first-line supervisors receive a wage which is either a certain percentage or dollar amount above those of the employees under their supervision. This generally recognized personnel principle would be impossible to implement under Section 124 of S.1391.

Title II of the Bill focuses on limitations on hospital capital expenditures. Most health care officials now agree, as we do, that some limitations on expensive expansion programs, either for construction or equipment, are appropriate and much needed. However, we would face serious problems if S.1391 were enacted in its present form. Specifically 85 of our existing beds are housed in a 50-year-old building. The patients in these beds are often faced with difficulties relating to mechanical breakdowns. On particularly hot days, water is often not available; 12-14 patients have to share a single bathroom; there is no provision for oxygen or suction. In addition, studies done by outside consultants have revealed that many of our ancillary departments are desperately short of space - to the point where patient care is now sometimes compromised. Some of our specialty units require additional beds to respond to patient demand. As we interpret Section 1504, unless an exception were made, this Bill would restrict the addition of any beds, even those in the special care category, since the Philadelphia area now has more than four beds per 1000 population. No one can realistically

argue against establishing criteria for adding hospital beds, but it would seem more appropriate for the local planning agency to evaluate each situation on an individual basis. Under the proposed guidelines a hospital in a given health service area with over 100% occupancy might still not be able to add beds; this appears to be rather arbitrary.

Our ability to make necessary improvements to our patient care facilities would also be seriously hampered by the provisions of Section 115. This section allows for exceptions to be granted for renovations or replacement if costs relating to a renovation or replacement project causes hospital expenses to rise significantly and jeopardize the institution's solvency. Needless to say, applying for such an exception would not enhance the institution's credit rating and borrowing capacity. In addition, if our financial status were to deteriorate because of some of the reasons outlined above, it would be impossible for the institution to attract potential investors in tax-free bonds or support from local banks and lending institutions.

We have not yet been able to completely digest all of the complexities of the regulations nor are we able to render interpretations on all of the language. It does seem however that our much needed building program, in which we have already invested a considerable amount of energy, time and expense, would be in serious jeopardy.

To briefly summarize, we certainly applaud any attempt by our government to control inflation in a uniform fashion for all segments of the economy. However, it must be emphasized that health care institutions are among the most complex and their financial patterns and reimbursement mechanisms vary tremendously throughout the United States. We hope that, by illustrating a few specific examples of the effect S.1391 would have on one institution, we have been able to point out some of the inadequacies and inequities which are contained in this Bill in its present form. Perhaps the major one which bears emphasis is the negative impact which S.1391 would have on institutions like MCP which provide a large amount of free care. This Bill, as presently drafted, would basically penalize those hospitals that are giving free care to the indigent and would have no effect on those which ignore the health care needs of the poor. We honestly do not believe that this is the result intended by the Bill when it was initiated.

There is no doubt in our minds that, if S.1391 is enacted in its present form, patient services at MCP will have to be curtailed in order to meet these new requirements. Finally any thoughts of upgrading certain identified antiquated facilities would almost certainly have to be foregone - thereby worsening an already deplorable situation. It is, therefore, our hope that all parties concerned will give serious consideration to the problems which this Bill would cause for those institutions like MCP, who are already facing tremendous difficulties in serving their patients because of existing poor reimbursement mechanisms.

Recommendations to Strengthen S.1391

- The cost ceiling on each payment category should be eliminated. This would permit hospitals to recover their losses incurred by providing free care while still maintaining an overall cost ceiling.

- Those hospitals which are not reimbursed their costs for out-patient care should be allowed to raise revenues to compensate for free care.

- All hospitals should be allowed to raise charges sufficiently to break even after depreciation while complying with cost ceilings. This would benefit only those hospitals that provide free care while restricting other institutions.

- The base accounting year should be the most recent fiscal year ending prior to enactment of the legislation.

- First-line supervisory personnel should be exempt from the restrictions of the cost ceilings.

- Regulation of capital expenditures should be left to the discretion of the Health Systems Agency which were established by PL 93-641 to perform this function.

- The Health Systems Agency should be given the power to define the appropriate functions of various hospitals and identify those that should become regional centers.

- Priority for capital funds should be given to the establishment of regional centers.

- Priority should be given to allocating funds for construction of hospitals in economically depressed areas.

- Incentives should be provided for hospitals to introduce energy conservation measures in either ongoing operations or new construction projects.

- Provision should be made to allow hospitals to proceed with new construction projects without penalty, provided that the hospital has submitted its application to the local Health System Agency prior to October 1, 1977 (assuming, of course, that the project receives the approval of the HSA).

/cs

Medical Society of the County of Kings

The Academy of Medicine of Brooklyn, Inc.

1313 Bedford Avenue • Brooklyn, N. Y. 11216 • INgersoll 7-9000

MAY 25,1977

TO: SENATOR EDWARD M.KENNEDY
UNITED STATES SENATE
WASHINGTON, D.C. 20510

FROM: STANLEY I.FISHMAN,M.D.
CHAIRMAN
COUNCIL OF HOSPITAL MEDICAL STAFFS
MEDICAL SOCIETY OF THE COUNTY OF KINGS

FOR INFORMATION

TESTIMONY FOR DELIVERY BEFORE THE NEW YORK STATE ASSEMBLY PROGRAM SUBCOMMITTEE ON HEALTH COSTS AND FINANCING ON FRIDAY, MAY 20, 1977.

I AM STANLEY I. FISHMAN, M. D., ENGAGED IN THE PRIVATE GROUP PRACTICE OF INTERNAL MEDICINE IN BROOKLYN, REPRESENTING THE MEDICAL SOCIETY OF THE COUNTY OF KINGS WITH OVER 3200 ACTIVE MEMBERS. I AM THE CHAIRMAN OF THE COUNCIL OF HOSPITAL MEDICAL STAFFS OF BROOKLYN, AND THE PRESIDENT AND CHAIRMAN OF THE BOARD OF DIRECTORS OF THE KINGS COUNTY HEALTH CARE REVIEW ORGANIZATION, THE FEDERALLY-FUNDED P.S.R.O. FOR BROOKLYN. WE APPRECIATE YOUR COURTESY IN INVITING OUR COMMENTS.

SEVERAL FACTS-OF-LIFE IN THE DELIVERY OF HEALTH CARE ARE WELL-RECOGNIZED IN BROOKLYN:

1. THE EXCESS, POORLY-USED, HOSPITAL BEDS IN BROOKLYN RESULTED FROM A MISCALCULATION IN ESTIMATING FUTURE NEEDS BASED ON EXPECTED POPULATION GROWTH.

2. A CONSIDERABLE REDUCTION (OVER 1200 BEDS) HAS ALREADY OCCURRED BY A REDUCTION IN THE NUMBER OF HOSPITALS TO 29 PRESENTLY FUNCTIONING FROM OVER 40 A FEW YEARS AGO.

3. NEIGHBORHOODS AROUND CLOSED HOSPITALS HAVE QUICKLY BECOME PRIME EXAMPLES OF URBAN BLIGHT, WITH BURNT-OUT BUILDINGS, FILTH, AND TOTAL UNEMPLOYMENT LEADING TO TOTAL ABANDONMENT OF WHOLE BLOCKS TO DRUG-ADDICTS AND RATS.

4. THE PRESENT SYSTEM OF REIMBURSEMENT TO HOSPITALS ON THE BASIS OF NUMBER OF BEDS OCCUPIED RESULTS IN THE HOSPITALIZATION OF MARGINAL CASES IN ORDER TO "KEEP THE CENSUS UP".

5. AT THE SAME TIME, IT IS NECESSARY TO CONTINUE HOSPITALIZATION OF MANY PATIENTS FOR LONGER PERIODS THAN MEDICALLY NECESSARY BECAUSE OF THE SHORTAGE OF LONG-TERM CARE BEDS TO WHICH THEY SHOULD BE TRANSFERRED, RESULTING IN OVER-USE OF EXPENSIVE ACUTE-CARE BEDS.

BECAUSE SO MANY HOSPITALS HAVE ALREADY CLOSED IN BROOKLYN, IT WOULD BE COURTING DISASTER TO CONSIDER THE FURTHER CLOSING OF ENTIRE HOSPITALS. MANY

HOSPITAL EMPLOYEES ARE MARGINALLY EMPLOYABLE, AND THE HOSPITAL JOB REPRESENTS THEIR POINT OF ENTRY INTO THE SOLID CITIZEN WORK FORCE. TO CLOSE THEIR INDUSTRY AND FORCE THEM ON TO THE WELFARE ROLLS IS TOO HIGH A PRICE TO PAY, EVEN IF THE FEDERAL GOVERNMENT WERE TO TAKE OVER ALL WELFARE COSTS FROM THE CITY AND STATE. AND ANY FURTHER BLIGHTING OF WHOLE NEIGHBORHOODS IN BROOKLYN MUST HAVE A DELETERIOUS EFFECT ON SURROUNDING BOROUGHS IN THE CITY, AND EVENTUALLY IN OTHER COUNTIES WITHIN THE STATE.

MOREOVER, ONCE WHOLE HOSPITALS ARE CLOSED AND DECAY, THEIR BEDS ARE IRRETRIEVABLY LOST TO THE HOSPITAL SYSTEM. SHOULD THE DECREASE IN POPULATION BE REVERSED, THE DISRUPTION TO HEALTH CARE AND THE COST OF NEW FACILITIES IS FRIGHTENING. AND THERE IS NO REASON TO BELIEVE THAT THE DEMOGRAPHIC PREDICTORS WILL BE LESS WRONG IN THE FUTURE THAN THEY HAVE BEEN.

THEREFORE, IT MAKES MUCH MORE SENSE TO CONVERT OVER-USED ACUTE-CARE BEDS IN EACH HOSPITAL TO LONG-TERM CARE FACILITIES. THE EFFICIENCY WITH WHICH PATIENTS CAN BE TRANSFERRED TO MORE ECONOMICAL LONG-TERM CARE BEDS, AND RETURNED TO ACUTE-CARE SECTIONS WHEN SERIOUSLY ILL HAS BEEN DEMONSTRATED REPEATEDLY IN THOSE HOSPITALS WITH ADJOINING LONG-TERM CARE AREAS. OBVIOUSLY, THE BEDS TO BE CONVERTED WOULD BE THE ONES LEAST ADVANTAGEOUS FOR THE RENDERING OF ACUTE CARE.

THE DETERMINATION OF WHERE, WHEN, AND HOW BED ALLOCATION SHOULD BE CHANGED MUST BE THE RESPONSIBILITY OF A COMMISSION DIRECTLY RESPONSIBLE TO THE LEGISLATURE AND SHOULD INCLUDE EQUAL REPRESENTATION FROM THE STATE HOSPITAL ASSOCIATIONS, THE MEDICAL SOCIETIES, THE THIRD-PARTY PAYORS (INSURERS), THE HEALTH SYSTEMS AGENCY, AND THE PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS. THE COMMISSIONER OF HEALTH AND THE SUPERINTENDENT OF INSURANCE SHOULD MAKE RECOMMENDED CHANGES TO THE COMMISSION, AND SHOULD BE CHARGED WITH THE RESPONSIBILITY OF EFFECTIVELY IMPLEMENTING THE COMMISSION'S DECISION. EXPERIENCE HAS SHOWN THAT GIVING THE RESPONSIBILITY TO ANY ONE GROUP, NO MATTER HOW WELL-MEANING (INCLUDING THE STATE HEALTH DEPARTMENT OR THE H.S.A.), RESULTS IN ILL-ADVISED DECISIONS BASED ON ONLY PARTIAL KNOWLEDGE, OFTEN USING OUT-DATED STATISTICS. THE COMMISSION MADE

UP OF MULTIPLE GROUPS WOULD INSURE THAT ALL FACETS OF THE PROBLEM ARE RATIONALLY CONSIDERED.

IN ADDITION, THIS COMMISSION SHOULD DEVISE A NEW SYSTEM OF PAYMENT TO HEALTH FACILITIES BASED ON ACTUAL COSTS INCURRED OR PROJECTED, WITH APPROPRIATE ADJUSTMENT ON A QUARTERLY BASIS. RATE OF PAYMENT SHOULD BE UNIFORM REGARDLESS OF THE SOURCE OF PAYMENT, SO THAT NO PATIENT WOULD BE PREFERRED TO ANOTHER. (AT PRESENT, HOSPITALS PREFER MEDICARE PATIENTS, WHILE NURSING HOMES INSIST ON MEDICAID PATIENTS TO AVOID RETROACTIVE DISALLOWAL OF PAYMENT.) THE SYSTEM OF REIMBURSEMENT BASED ON OCCUPANCY RATES MUST BE ELIMINATED, SINCE IT ENCOURAGES MARGINALLY NECESSARY HOSPITALIZATION OF PATIENTS DESIGNED TO HELP THE HOSPITAL "STAY EVEN." ALTHOUGH EFFECTIVE UTILIZATION REVIEW PROCEDURES HAVE RESULTED IN DECREASED MIS-UTILIZATION, THE TOTAL ELIMINATION OF UNNECESSARY OR PROLONGED HOSPITALIZATION DEPENDS ON DIVORCING OCCUPANCY RATE FROM REIMBURSEMENT. THE PRESENT SYSTEM IS AKIN TO THE PRIMITIVE SYSTEM OF REIMBURSING VOLUNTEER FIRE DEPARTMENTS ACCORDING TO THE NUMBER OF FIRES EXTINGUISHED. THAT SYSTEM RESULTED IN COMPETING DEPARTMENTS RACING EACH OTHER TO FIRES, SABOTAGING OF EQUIPMENT, AND SOMETIMES THE PURPOSEFUL SETTING OF FIRES TO CREATE A NEED FOR REIMBURSEMENT. THE HOSPITAL SYSTEM MUST OPERATE ON A STANDBY BASIS AND BE COMPENSATED ACCORDINGLY, JUST AS THE FIRE DEPARTMENT NOW IS. THE SIZE, LOCATION, TYPE OF FACILITY, AND EFFECTIVE UTILIZATION OF THIS SYSTEM IS THE RESPONSIBILITY OF THE VARIOUS GROUPS WHICH SHOULD MAKE UP THE COMMISSION. THERE IS NO DOUBT THAT THEY CAN DEVISE A SYSTEM JUST AS RESPONSIVE TO THE PUBLIC NEED AS THE FIRE DEPARTMENT IS. IN ADDITION, A PEER-REVIEW SYSTEM FOR HOSPITAL MANAGEMENT WOULD BE A MAJOR STEP TOWARD ENSURING EFFICIENT OPERATION AND COST-CONTAINMENT IN ALL HOSPITALS - PROPRIETARY, VOLUNTARY, AND GOVERNMENT HOSPITALS ALIKE.

WE THANK YOU FOR THE OPPORTUNITY TO PRESENT THESE COMMENTS AND WISH THE COMMITTEE WELL IN THE PERFORMANCE OF ITS TASK. WE STAND READY TO HELP YOU AT ALL TIMES.

minnesota hospital association

serving nonprofit hospitals and nursing homes

June 13, 1977

Dr. Stuart Shapiro
Senate Subcommittee on Health
Committee on Human Resources
4228 Senate Office Building
Washington, D. C. 20510

RE: S. 1391

Dear Dr. Shapiro:

Attached are the comments of the Minnesota Hospital Association on the Hospital Cost Containment Act of 1977, S. 1391. We appreciate the opportunity to submit this for the record of the Health Subcommittee of the Senate Committee on Human Resources.

If the committee members have any questions or comments, I would be pleased to receive them.

Sincerely,

Stephen Rogness
Executive Director

SR:cm
Attachment

2333 UNIVERSITY AVENUE SOUTHEAST • MINNEAPOLIS, MINNESOTA 55414 • PHONE (612) 331-5571

minnesota hospital association

serving nonprofit hospitals and nursing homes

June 13, 1977

MINNESOTA HOSPITAL ASSOCIATION

COMMENTS ON S. 1391

THE HOSPITAL COST CONTAINMENT ACT OF 1977

SUBMITTED TO THE HEALTH SUBCOMMITTEE

OF THE SENATE COMMITTEE ON HUMAN RESOURCES

The Minnesota Hospital Association appreciates this opportunity to submit for your consideration our comments on S. 1391, "The Hospital Cost Containment Act of 1977."

We understand the compelling reasons for the development of this proposal now before the subcommittee, but we believe there are better ways for Congress to deal with the issue of rising health care costs. Therefore, we oppose S. 1391.

We support the stance of the American Hospital Association. We will not reiterate in detail the American Hospital Association's comments regarding the major reasons for the rise in hospital costs. The same factors AHA identified -- general inflation, growing public demand, intensification of services, modernization and maintenance of service capacity, manpower development, and the cost of government regulation -- are impacting on the costs of Minnesota hospitals.

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Instead, MHA comments will focus on the major reasons we oppose S. 1391 and conclude with some alternatives which Congress should consider.

REASONS FOR MHA OPPOSITION TO S. 1391

1) It is inequitable to single out one segment of the economy for controls.

The control mechanism is on inpatient revenue which in effect will result in price controls. Price controls on only one portion of the economy is unworkable as we discovered during the last years of the economic stabilization program.

The St. Cloud Daily Times, in its editorial on April 27, speaks to the unfairness of this plan (Attachment A). In its concluding paragraph, the Times says:

> "...Carter's singling out of hospitals to punish for higher costs that the hospitals are not the primary cause of is unfair. His proposals should not be adopted on this. Efforts should be concentrated on easing inflation generally. Easing of inflation also would ease health care costs."

The Princeton Union-Eagle also voices similar concerns in its May 19, 1977 Editorial (Attachment B).

2) It would seriously jeopardize Minnesota's hospitals' ability to continue to provide quality patient care.

One of the chief factors in rising hospital costs above the general inflation rate has been the assimilation by the industry of new breakthroughs in medical technology. This has resulted in hospitals being able to provide an increasing number of sick people with readily accessible diagnostic and treatment systems which only a few years ago had a

very limited availability. This has led to saving many lives as well as restoring to full health countless citizens.

If hospitals had been living under tight controls (as are being suggested now) for the last ten years, coronary care units, intensive care facilities and kidney dialysis networks might not be available today throughout Minnesota, as is the case.

In his April 30, 1977 guest editorial (Attachment C) Ron Freeberg, Rochester Post Bulletin Government Reporter, wrote about his care in Rochester Methodist Hospital after a major heart attack. He wonders what will happen to the hospital's ability to provide life saving treatment under the Carter Plan. He says:

> "...Sure hospital costs are high. But when higher costs are compared with improved care, better trained personnel and advanced equipment, the price is not TOO high.
> Cost ceilings could only push medical care backwards. Hospitals would become warehouses for the sick -- a place to go to die; not recover from serious illness..."

3) It disregards existing control mechanisms which were designed to modify hospital cost increases.

Congress has already passed legislation which should be strengthened, not disregarded. The Professional Standards Review Organizations (PSROs) are designed to determine that all medicare and medicaid hospital stays are "medically necessary". In Minnesota the PSRO systems are established. The metro area PSRO particularly has demonstrated its effectiveness in assuring that only those patients with medical need are hospitalized -- and stay for only those days where need exists. The PSRO system should be strengthened because it gives the decision

making responsibility to the appropriate level -- the hospital medical staff and/or a peer review organization.

Second, P.L. 93-641 establishes Health Systems Agencies throughout the nation with broad powers to review and certify the need for hospital expansions. It provides a means whereby a local, consumer-majority body, the Health Systems Agency Board, using federal guidelines, decides what the health care system should include in their local area. Again, it's a system giving responsibility to a local, democratically-selected body. Congress should assure that it is implemented equitably throughout the nation.

4) *It inappropriately puts the burden of controlling demand on the supply side of the demand/supply equation.*

Placing hospitals in the position of decreasing admissions in order to "afford" to continue giving care implies that hospitals can control the number of admissions they receive. This is not the case. Physicians make the decision on whether or not a particular patient should be admitted. Further, the PSRO mechanism judges whether or not the admission is justified. Thus, to decrease admissions, Congress should consider controls on consumer demand rather than hospital admissions.

5) *It sets arbitrary fixed limits on all hospitals which are inequitable.*

Hospital financial requirements vary throughout the state. Through the Minnesota Rate Review Program (MRRP), which reviews the financial requirements of almost all the state's hospitals, we can observe the discriminatory effect the 9% ceiling on inpatient revenue would have.

A word about our rate review program: MRRP, which has been operating for approximately 2 years, reviews and approves the budgets of participating hospitals based on their financial requirements. In addition to

reviewing past year, current year and budget year data, the consumer-dominated rate review panel judges the performance of the hospital as compared to like facilities throughout the state.

The following are examples of the impact of the proposed limit on specific hospitals which have recently been reviewed and approved.

Example A - Based on current trends, a large hospital outside the Twin City area has projected an increase in admissions of 3%. After extensive review by the rate review panel, the hospital received approval of their budget of $32.6 million. However, if the 9% cap and the penalty for increased admissions had been in force for 1977, this hospital's financial requirements would be reduced by $3.2 million; almost a 10% loss.

Example B - A small rural hospital has projected their financial requirements to be $545,000 with an increase in admissions of 25% (they added a long-sought doctor to their medical staff). The rate review panel reviewed and approved their budget for 1977. However, if they were to be limited by the provisions of S. 1391 for 1977, they would suffer a loss of $80,000 or 15% of their total operating budget.

Example C - A large metropolitan area hospital has much the same circumstances as cited in Example A. Increasing admissions penalizes them to the tune of $3.5 million out of a total approved budget from inpatient revenues of $34 million; a 10% reduction in their approved program of service to sick people.

The only way the above three hospitals would adapt to the proposed limits is to cut back on services they now provide -- either through cuts in

vital personnel or through reductions in services. None of the above hospitals could "afford" to make these cuts because they would seriously jeopardize their continuing ability to serve their patients.

Example D - A small rural hospital has had a 10% decrease in admissions. According to the limits in S. 1391, this hospital would have been able to receive $1,316,000 inpatient revenue. However, the rate review panel, in reviewing their financial requirements, approved their budget for $1,195,500. Thus, under S. 1391, this hospital would have been able to gain 10% more than their financial requirements.

Example E - Similar to the previous example, a metropolitan hospital received rate review approval for 9% less inpatient revenue than would have been allowed under H.R. 6575.

These five examples point up the inequities of the proposed caps and support the compelling argument that all hospitals must be judged individually based on the needs of their communities.

6) It uses the "GNP deflator" as its device to measure hospital inflation which is an inappropriate gauge to the inflationary forces experienced.

Mr. McMahon, AHA President, discusses this issue in his testimony showing that the market basket from which hospitals purchase their supplies and services has been going up at a rate faster than the GNP deflator. We feel AHA's guides to the hospitals' costs, The Hospital Cost Index (HCI) and The Hospital Intensity Index (HII), are the most accurate reflections of the industry trends and should be used as the federal government's indicators.

95-195 O - 77 - pt. 2 - 39

7) It places the controls at the federal level -- the most remote level from the citizens who demand the services and who make the decisions on what services should be made available.

The planning controls of P.L. 93-641 are given to the local Health Systems Agencies, and the quality assurance/utilization review decisions are required of local PSROs. Plus, in Minnesota, our Rate Review Program utilizes local citizens and providers to judge the reasonableness of hospital budget needs. This local control is a guiding principle of the U.S. democracy. However, S.1391 would remove that local decision making in deference to federal level control. We believe this is contrary to the basic premises of the country and contrary to sound public policy.

8) It provides no reasonable mechanism for adjusting revenue requirements if additional capitalization is approved.

If a hospital receives a certificate of need through the P.L. 93-641 process, it could not get a revenue adjustment under S. 1391 to pay for the capital project unless the cost impact would cause them to be virtually insolvent. And since most financial institutions rate bonds or approve loans on the basis of solvency, it would be virtually impossible for the approved project to be financed.

ALTERNATIVES

The Minnesota Hospital Association is very concerned about the problem of hospital cost increases. Our rate review program, our support of the PSROs and the Certificate of Need Law are significant demonstrations of our commitment and concern. While we do not support the system designed in S. 1391, we do support constructive alternatives. The following are areas in which we think Congress should commit its efforts

in seeking ways to reduce the inflation of health care costs.

1) Public Expectation and Demand

The current third-party payment systems, including medicare and medicaid, have been heavy contributors to the increasing cost of health care through their open-ended promises to the public. A. F. Ehrbar suggests some intriguing solutions to this problem in his February '77 Fortune article titled "A Radical Prescription for Medical Care". He proposes the establishment of effective means of getting the consumer to be an active participant in his health care decisions. Others have advocated this, too, saying that we must give consumers the financial incentive to stay healthy. The Red Wing Republican Eagle, on April 29 (Attachment D), commented on the control program and ended its editorial by saying:

> "...Essential No. 1 for slowing America's speeding health cost escalator, we believe, is to persuade individuals to give more concern to health in their lifestyles -- eating, smoking, drinking, exercise, auto driving.
>
> Essential No. 2 is to attack the third-party payment problem by making everybody pay out of his pocket more of the initial cost of seeing a doctor or entering a hospital."

Clark Havighurst, in the paper he gave at the recent National Health Forum, also identified consumer risk sharing as a significant issue and suggested several ways to get the consumer into the decision making process.

2) Strengthen current regulatory efforts -- remove regulatory barriers

As mentioned in previous statements, we believe P.L. 93-641 and the PSRO program can work and have significant impact if given Congres-

sional backing. Both programs take time to implement; but based on Minnesota's experience, they can (and will) work if given appropriate federal support.

Through our state's certificate of need (CON) program, we've seen a considerable change in the rate of increase in inpatient hospital capacity. In the 5 years prior to enactment of the CON law (1971), there was an annual rate of increase in licensed beds of 2% (17,281 to 18,996). In the 5 years after passage of the CON law, the rate has been 0.8% (18,996 to 19,769).

While the impact of PSRO is hard to measure effectively, the reduction of the average length of stay and the increased acuity of illness of patients in hospitals is an indicator that "medically unnecessary" admissions have been significantly reduced, and the length of time patients convalesce has been decreased.

We recognize there are hospitals with underutilized capacity which could be used for other community health needs. Congress should remove regulatory barriers that currently restrict this conversion and provide incentives for hospitals to undertake new roles which are consistent with community health needs.

3) State Prospective Rate Review Mechanisms

As our previous comments indicate, we believe the Minnesota Rate Review Program (MRRP), through its consumer-majority panel decision making process, is the appropriate means of judging the financial requirements of hospitals. Through MRRP, hospitals receive approval of their budgets prospectively. According to our analysis, the rate of increase of hospital revenue in 1977 should be around 11% as compared to 15% in 1976.

We believe Congress should recognize statewide rate review systems as a means of controlling hospital cost increases and encourage their development. Also, Congress should mandate medicare and medicaid participation in paying hospitals on the basis of their prospective rates rather than the much criticized retrospective cost based forumla presently in use.

Further, for those states which do not have rate review systems, the provisions of H.R. 7079 and S. 1470, recently introduced by Representative Rogers and Senator Talmadge respectively, presents an approach that deserves Congressional consideration.

CONCLUSION

We recognize the serious nature of the problem of rising health care costs; and through voluntary and state regulatory efforts, MHA has actively participated in attempts to modify cost increases. S. 1391 does not provide the appropriate answers to the problem, and we urge Congress to seek reasonable alternatives.

MHA wishes to thank the Health Subcommittee for this opportunity to present its views on S. 1391 and welcomes any questions or comments.

ATTACHMENT A

4 Daily Times, St. Cloud, Minn. Wed., April 27, 1977

Opinion

Hospital cost plan unfair

President Carter's plan to control hospital costs seems a grossly unfair burden on one small segment of the economic population. His plan seems based on blaming hospitals for ills that probably stem basically from elsewhere.

Carter's plan would set a ceiling of 9 per cent on increases of hospital charges and would attach tight financial controls to 6,000 hospitals in the nation. Carter cites inflation and higher costs of more sophisticated equipment as the reasons for an increase in health care costs to patients and insurance companies.

It is unfair to assume that hospital costs have been raised arbitrarily. Costs rose 11.5 per cent for St. Cloud Hospital this year, for instance. A cost of living raise for hospital employes caused the bulk of it, according to hospital officials. Inflation's impact on supplies and fuel caused another large part of it. Furthermore, federal legislation, state legislation and federal regulations mandated increased spending over the previous year. A relatively small part went to improving and expanding equipment for treating patients.

The primary cause of higher health costs evidently is the primary cause of higher costs for everything — inflation. Beyond inflation is the continuing development of more and more effective treatments that cost more to administer than earlier forms of treatment.

If a hospital's staff feels an expensive addition to hospital facilities would go unused, surely the addition would not be made. Under financial pressure just as are all other institutions, hospitals could not afford to build facilities without an indication of strong need for them. When the strong need is there, perhaps higher expenses to satisfy the health needs are warranted.

Carter's singling out of hospitals to punish for higher costs that the hospitals are not the primary cause of is unfair. His proposals should not be adopted on this. Efforts should be concentrated on easing inflation generally. Easing of inflation also would ease health care costs.

ATTACHMENT B

The Princeton Union-Eagle
Thursday, May 19, 1977

Editorials

A ceiling on hospital charges

President Carter's suggestion for a price ceiling on hospital charges is a simplistic solution to a complicated problem. No price ceiling works unless it is accompanied by price ceilings on the elements making up the overall cost. Are hospital workers to have wage ceilings, and not other workers? Are hospital charges going up rapidly, as indeed they are, because of overcharges? Hospital trustees struggling to balance budgets will not agree.

Our inquiry indicates that a major factor is the rapid growth of medical technology. So much has been developed in the way of equipment and personal services that the real question is how to deliver the medical care now possible in an equitable way at an appropriate price.

An arbitrary limit on the increase that could take place in hospital charges would stifle medical research and the use of its results. Medical services are not stable commodities that can be held to a cost of living fluctuation. Medicare has been a boon to one segment of the nation's population. Hospitalization programs cover many more, but there remains the overall problem of equity for those without coverage. Can we not learn from the experiences of Britain, Sweden and other countries to work out a sound program that would bring quality medical and hospital care within the reach of all citizens? That is the pressing challenge and a suggestion of a ceiling on hospital charges contributes very little to the solution.

ATTACHMENT (

Post-Bulletin
Editorial

Page 12
Saturday, April 30, 1977

Charles Withers - Editor
Robert Withers - Publisher

Guest Editorial—

I Wouldn't Want to Stake My Life on It

By RON FREEBERG
Post-Bulletin City Government Reporter

Two months ago I might have applauded the proposal by President Carter for a ceiling on hospital costs.

That was before my personal experience with a major heart attack and the extraordinary recovery process provided me at Rochester Methodist Hospital's Cardiac Care Unit.

Now I wonder if I would have even survived the attack had such a cost ceiling been imposed on hospitals years ago.

Coronary care has improved dramatically in the past few years. The advanced techniques, modern equipment and greater skillls of highly trained personnel delivering such care costs money.



Freeberg

The costs, naturally, are passed on to the patient. Likewise, any cutbacks necessary to meet arbitrary cost ceilings would be reflected in the care available to patients. Further advances are being made almost daily and they will certainly increase costs.

Heart attacks, like any serious illness, are expensive. But if I suffer another I don't want less care at bargain prices. I will want at least the same or better care even if the cost is higher.

Less than 10 years ago, a heart attack victim could expect to spend between four and five weeks in the hospital — confined to bed much of that time.

Today, the hospital stay ranges between 9 and 15 days, depending upon severity of the attack.

And the care is individualized rather than regimented treatment for every case.

Both Methodist Hospital and St. Marys Hospital adopted a "team" approach to cardiac care during the past three to four years because a heart attack involves much more than treatment of a damaged heart.

There are human and emotional aspects. The patient suffers depression, anxiety, fear.

I felt my life had ended at age 44 even though I was very much alive. The fear I experienced was not of dieing, but of living — being a so-called "cardiac cripple."

Yet, in just 15 days the dedicated and skillful [illegible] efforts of the coronary care team at Methodist Hospital had me not only walking out the door, but looking forward to a long and active life.

I was not a "model" patient. Often I was ornery, resentful and thriving on self-pity. The "team" remained cheerful, attentive and ever willing to help.

Included in the coronary care team are a primary doctor and nurse, internists, psychiatrist, chaplain, therapists, dietician, pharmacist and various technicians and nurses.

During the first week of intensive care, the heart attack victim has one nurse assigned almost exclusively to him.

The nurse may have one other patient — never more than two. Other nurses in the cardiac unit also assist.

Seldom was it necessary to signal for a nurse — they tended to anticipate every need. When I did signal for help, the nurse responded within scant seconds. Their attitude was always kindly.

What would happen in a few years if cost ceilings are imposed and hospitals are forced to cutback on the number, training or pay of such coronary care teams?

Would there even be such teams? I'm certain the few that remained would be demoralized or ill-trained. They would offer minimal service and view patients as workloads and not individuals.

Instead of one nurse for each two patients, it could be a nurse for every 10 or 20 patients. She could dash from room-to-room, tossing out medication like newsboys on home delivery routes. There would be no time for tending to the human cares of patients. Maids and janitors could help out harried nurses in distributing food trays or making beds, etc.

Sure, hospital costs are high. But when the higher costs are compared with the improved care, better-trained personnel and advanced equipment, the price is not TOO high.

Cost ceilings could only push medical care backwards. Hospitals would become warehouses for the sick — a place to go and die; not recover from a serious illness.

The same recovery in the same amount of time with the same specialized and individual care could never be accomplished at stable or reduced costs.

2 Republican Eagle Red Wing, Minn. Fri. Apr. 29 '77

ATTACHMENT D

EDITORIALS

Price controls on hospitals?

"Hospitals . . . many of them have become obese. They are not trim."

So says HEW Secretary Joseph Califano, and that's the thinking behind the Carter Administration proposal sent up to Congress Monday to impose federal price controls on hospital charges.

Offhand, we'd think that hospitals ought to be able to live within a 9 percent legal ceiling on annual increases (plus one percent for exceptions). That doesn't sound too difficult.

And it's true that hospitals aren't subject to the normal competitive business factor that works to keep charges down. Few people "shop" hospital rates before deciding where to go to be sick or have surgery — or be taken when an ambulance transports them unconscious from a highway wreck.

Hospital rates have been rising outrageously, too — far faster than the overall Consumer Price Index. The average cost for a patient's hospital stay jumped from $311 in 1965 to $873 in 1974 to over $1,200 today.

According to the federal statisticians, the average American works almost two weeks out of each 52 to pay somebody's hospital costs.

At the same time, we're wary of the heavy and bureaucratic federal hand. In general, the experience with federal price controls has been dismal. How much will the federal controllers cost us? And there are always complexities when you start digging into particular rates for particular services within a hospital, and the cost factors behind them.

St. John's in Red Wing raised its rates by 6.8 percent and 6.6 percent, respectively, in each of the last two years. On the surface, it could live within the Carter-proposed 9 percent.

But an administrator's worry, when the rest of the economy is uncontrolled, is, "Who will assure me that my malpractice insurance costs, my utility and food costs, my labor rates will permit me to stay within the 9 percent?"

There are other ongoing efforts, too, to get a handle on hospital cost escalation.

Just last week, St. John's had to go before Minnesota's "voluntary" Rate Review Program. A panel of three hospital professionals and four non-hospital "consumers" grilled St. John's thoroughly on aspects of its cost figures. Dietary costs, for example, received some firm probing.

In the end, St. John's new rates of last January won approval — but other hospitals have been denied approval and ordered to institute rollbacks.

So we're withholding judgment for a while on this Administration plan, but mostly we're heartened by the indications out of Jimmy Carter's inner circle this week that the Administration is backing off from the Carter campaign pledge to institute an overall national health insurance program.

Budget-balancing seems to be "in" at the White House now, and the budget-balancers must be appalled at what it would cost to undertake to pay all bills for every American's medical care.

A report is due Sunday from the blue-ribbon Administration group studying welfare reform, and that —not health insurance — is said to be ticketed as the big Jimmy Carter domestic initiative.

Curiously, a White House question-and-answer backgrounder on the hospital price control proposal cites the clue to what we see as the central ailment in America's whole mess of out-of-hand health-medical costs.

Q. "What . . . are some of the factors causing increases in health costs?

A. "The first factor is a third-party payment system that leaves patients and their physicians largely unconcerned with what a hospital stay costs . . . More than 90 percent of hospital services are directly paid by someone other than the patient — by Medicare, Medicaid, Blue Cross or other insurance carriers."

Essential No. 1 for slowing America's speeding health cost escalator, we believe, is to persuade individuals to give more concern to health in their lifestyles — eating, smoking, drinking, exercise, auto driving.

Essential No. 2 is to attack the third-party payment problem by making everybody pay out of his pocket more of the initial cost of seeing a doctor or entering a hospital.

Missouri Hospital Association

P.O. Box 1044, 1233 Jefferson Street, Jefferson City, Missouri 65101
Phone (314) 635-6127

C. Duane Dauner
President

June 10, 1977

Senator Edward M. Kennedy
c/o Stuart Shapiro, M.D.
Subcommittee on Health
Committee on Human Resources
U. S. Senate
Washington, D. C. 20510

Dear Senator Kennedy:

Enclosed is a joint statement on the proposed Hospital Cost Containment Act of 1977, as adopted by the Hospital Association of Metropolitan St. Louis, Kansas City Area Hospital Association and Missouri Hospital Association.

We urge your consideration of the statement as you deliberate on the Hospital Cost Containment Act of 1977.

Respectfully submitted,

C. Duane Dauner, President
Missouri Hospital Association

CDD/bg

enclosure

POSITION STATEMENT ON THE PROPOSED COST CONTAINMENT ACT OF 1977 (H.R.6575 / S.1391) AND OTHER LEGISLATIVE PROPOSALS TO CONTROL HOSPITAL REVENUES

By

Hospital Association of Metropolitan St. Louis
Kansas City Area Hospital Association
Missouri Hospital Association

For the past several years hospitals have been faced with rapidly escalating costs and the resultant necessity to increase charges for services. The subject has become a matter of great public and governmental concern, causing an ever increasing and more intensive effort to find a mechanism for halting and reducing the level of expenditures for health care. Although hospitals are apprehensive that many of the proposals will place arbitrary restrictions on their fiscal affairs, they do share the interest of government in finding rational means to prevent the cost of health care from taking an ever increasing bite out of the nation's economy.

President Carter's administration attacked the question of increasing health costs as a priority and has prepared and introduced the "Cost Containment Act of 1977" (H.R.6575 / S.1391). Hospitals support the need for an effective approach to the containment of health costs; however, they recognize the complexity of cost elements and their entanglement with the market place and the entire economy. They cannot be in favor of any system which would not deal with this complexity in the context of the economic, social, and

historic forces which are at work. Therefore, we believe any legislation, to be effective, must include the following considerations which have not been given sufficient weight in the hastily prepared proposed Cost Containment Act of 1977.

HEALTH CARE IS A RIGHT?

With the passage of the Medicare-Medicaid Program in 1966, the Federal government committed itself to a philosophy which had been under debate for some time; that quality health care is a right of every citizen and should be available and accessible to all.

Since that time, other programs, spurred by increased public awareness and demand for service, have accentuated the public's acceptance of the philosophy of the right to health care with an accompanying expectation of almost daily improvements in life-saving health care technology. Hospitals have attempted to cope with public expectations and demands in a climate of rampant general inflation, costly improvements in technology, and imposition of the maze of costly regulations from all levels of government. Also, since 1966, passage of the variety of Federal legislation in areas governing employer-employee relationships, compensation, working environment, social conditions, and plant and operating safety has substantially contributed to the cost of attempting to provide ever increasing quality of care to more and more people.

In addition, it must be recognized that underlying moral and philosophical commitments are present in the minds of the American people that life is priceless

to be nurtured and maintained to the extent humanly possible regardless of the cost. The Cost Containment Act of 1977 would have the effect of restricting and even reducing the ability of the providers of health care to continue in the effort to live up to public expectations and demands. The economic constraints contained in the bill, if it is enacted in its present form, would force hospitals to cut back in the effort to attain the goal of quality health care for all.

NEED FOR NATIONAL HEALTH POLICY

Perhaps the most important item on the agenda of any discussion of health care legislation is the reaffirmation of the philosophy of the universal right to health care, or, if it is to be the case, the clear recognition and admission to the American public by government that economic problems cannot be solved and it is necessary to reduce health care expectations and demands. It must be recognized that health care providers exist within the framework of the general economy and that governmental promises cannot be fulfilled through pretending that hospitals are a cornucopia which can be made to magically function without regard for the pressures and forces at work in the market place.

THE COST AND THE BENEFITS

Many studies and reports are available from a great variety of sources, both governmental and private, which detail the factors and forces causing the escalation in health costs. Unfortunately, in the discussion and debate on the subject, if often appears that we are dealing with a large model hospital in

some average location. The fact is, we are discussing a great number of hospitals offering a variety of levels and mixes of services located in cities, towns, and rural areas across the nation.

In recent years, there has been a definite trend to satisfy the expected improvements in the sophistication and efficiency of hospital operations in every size and class of hospital even in the most out-of-the-way places. In achieving this, hospitals have made constant improvements in the management and administration of institutions, large and small. They have developed programs for the exchange of information and data, for the sharing of modern management programs and vital clinical and support services, all of which represent improvements in administrative efficiency. Often, this goes unrecognized in the heat of the debate on expenditures for health care.

The question must be asked, can government by simply enacting arbitrary controls, such as those called for in the Cost Containment Act of 1977, improve the efficiency of hospitals and the allocation of health services across the nation? History and experiences in other countries, as well as wage and price controls in this country, indicate that such mandates will not work.

GOVERNMENT AND HEALTH INDUSTRY COOPERATION

Hospitals recognize that the complex problem of rapidly escalating health care costs is real. Means must be found to deal with it.

Hospitals in Missouri and surrounding areas believe that the only successful solution will be an effective form of health industry and governmental cooperation which recognizes that hospitals are willing and anxious to contain and even reduce expenditures in a realistic manner. They believe that any effective program must contain allowances for regional and local differences, as well as acceptance of the fact that many of the cost elements of providing modern health care are beyond the control of hospitals.

In conclusion, the hospitals in Missouri and surrounding metropolitan areas are opposed to the Cost Containment Act of 1977 and urge that the Administration, the Congress, and the health industry work together in the development of a system which will attain the goal of cost containment without damaging the industry's ability to continue progress toward the objective of improving the health of people at every age and economic level.

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May, 1977

STATEMENT OF THE MONTANA HOSPITAL ASSOCIATION
TO THE
SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH,
COMMITTEE ON HUMAN RESOURCES, U. S. SENATE, ON
S. 1391 - HOSPITAL COST CONTAINMENT ACT OF 1977

June 17, 1977

Chairman Senator Edward Kennedy:

On behalf of the membership of the Montana Hospital Association and the sick and injured people of the state of Montana, I appreciate the opportunity to present this written testimony in opposition to the enactment of S. 1391, the Hospital Cost Containment Act of 1977.

In order to put our reasons for opposing this legislation in perspective, it is necessary for you to understand our state, the health care delivery system currently in existence and some of the programs Montana hospitals have developed over the past several years towards accomplishing their goal of delivering high quality hospital services at a reasonable cost.

Montana is the fourth largest state in the Union, having within its borders some 147,000 square miles of land, but its population of 730,000 is about the size of the city of Washington, D.C. Within our borders we have some 61 general hospitals, with 42 of the hospitals having 50 beds or less. One of the health regions which has 17 counties, contains 16 hospitals ranging from 8 beds in Jordan and Terry to 120 beds in Miles City. The total 17 county area is 48,588 square miles and exceeds in size the combined area of the states of Maryland, Massachusetts, New Hampshire, Delaware, Connecticut and New Jersey. It is larger than Ohio, Pennsylvania, New York and 12 other states. Many health facilities in this area are remote (often more than 50-70 miles from the next larger hospital). We have only 2 classified metropolitan areas in our state, namely, Billings and Great Falls, each with a population approaching 100,000.

MHA Statement on S.1391/page 2

As one can readily see, Montana is a rural state and as a result has developed a rural health system which naturally must consist of quite a number of small hospitals. These small facilities have developed referral patterns for patients channeling them into the larger cities when there is a need for a medical specialist.

While we have seen increasing improvements in transportation through construction of new highways, improved air travel and railroad, there is still a considerable problem traveling from community to community and this is sometimes further complicated during a severe winter. Our state is laced with many roads, some of them still dirt and/or gravel. In many areas narrow paved roads provide the major transportation route for people seeking medical care.

The 61 general hospitals have a total complement of 3,400 beds; the two V.A. hospitals have a total bed count of 282 and the other federal and state hospitals make up a total of no more than 150 beds.

Comments on S. 1391

In our opinion, the adoption of S. 1391 would effectively close many of our smaller facilities through the process of economic starvation as these small hospitals attempt to apply the extremely complicated formula contained in Title 1 of the bill.

The conceptual design of the bill is unsound, particularly in Title 1 which sets for the transitional hospital cost containment revisions and outlines the formula which would utilize the "GNP deflater" published by the Department of Commerce. While on the surface it appears that all hospitals would be able to increase their charges 9% over the past year, it does not necessarily ring true, particularly when one takes into account major changes and mixes in the patient load. This can be seen when increases in the total allowable inpatient revenue would remain constant where patient load, measured by admissions increased 2% or decreased by 6% (decreased by 10% in the case of hospitals with fewer than 4,000 annual admissions).

Simple economic theory tells us that although the proposed program purports to lower hospital "costs", without some control on other segments of the economy and on medical care demand, the proposal will do nothing to control costs. It will control only the amount of payments for services provided. It is totally unreasonable for the government to assume that the total amount of medical care can continue to increase or even stay at the same level while the amount spent on care remains fixed.

The present day extensive regulation of hospitals through the Medicare program is based on an assertion that federal dollars not be wasted, that accountability for government dollar expenditures is the first concern. However, the unstated objective in manipulating hospital payments appears to be to limit federal spending to Social Security Administration funds and Congressional appropriations. Consequently, the Department of Health, Education, and Welfare continually defines and redefines allowable costs for hospitals.

After 8 years of being directed and controlled through Medicare regulations, private hospital corporations are now almost as tightly controlled as military, veteran and public health hospitals. The only significant remaining difference is that HEW actions have not saved money, but have shifted unallowable costs to the total responsibility of non-Medicare patients. HEW has been practicing cost shifting, rather than cost saving.

Should the federal proportion of patients be further expanded beyond Medicare and Medicaid and encompass the national health insurance program, control will then be as strong as in government-owned hospitals. Currently, the result of having an average of 40-45 percent total revenues coming from federal sources allows the federal government to escape responsibility for deficits in operations as well as the freedom to carp about the high cost of hospital care.

To continue a federal program of cost based payments to hospitals is to keep the cart before the horse. The principle is the same as the local super market

permitting the federal government to control their accounting systems, pricing policies, profit centers, depreciation, expansion and inventories, simply because they accept federal food stamps from their customers.

The Montana Hospital Association is certainly sensitive to the present cost of health care and has developed over the past years several programs which are currently underway in an attempt to help hospitals continue to provide services at the lowest possible cost without jeopardizing quality and availability. All medical costs, including hospital care, have climbed sharply as a direct result of increasing demand for services, new expensive technological advances, energy and insurance, inflation and last but not least, the government involvement in the medical field.

Through this proposed legislation, the present Administration is attempting to initiate a program to moderate health expenditures, while on the other hand, it is sponsoring legislation to increase the amount of care received through promises of expanded federal health programs. An example of one of the new programs recently enacted is the Child Health Assessment Act of 1977.

In addition, there are other forces at work on the health care market: the increase in the over-65 population which spends three times as much for health care as the rest of the population, and the expectations of our citizens who, through precedent, government promise and the media, have come to expect the finest care with little or no out-of-pocket expense.

These influences on the medical system are more subtle than the obvious increases in minimum wage, malpractice insurance costs, new equipment costs, unionization, etc. Taken together, all of these influences put the medical care industry in a dangerous situation. As the demand and intensity of services increases and the charges capped, a form of nonprice rationing takes over which will result in longer waiting periods, less personal care, decreasing of quality of services received by the people, and shorter hours of service. S. 1391 unfairly regulates one segment of the economy while the rest goes unchecked.

Hospitals in Montana faced with the general overall increase of 17% for energy, 300% increase in professional malpractice insurance and additional like increases cannot expect to remain in business and provide the essential services required unless they can recover their costs through increasing charges sufficient to provide for a reasonable increase of wages to personnel and provision for replacement of inadequate or in some cases, unsafe facilities. This is not a hospital cost containment act, it is a hospital price control and hospital bankruptcy act.

Congress must surely recognize that other legislation recently enacted, namely, the Planning Process and the inherent cost savings implications under P.L. 93-641 and P.L. 92-603, have not been allowed adequate time to develop procedures for controlling the expansion of "excess beds and expensive equipment" and decreasing the length of stays in certain areas of the country where length of stay is still above the norm developed by the professional standards review organizations. Passage of S. 1391 would supercede all of the current efforts being made by the Health Systems Agency and the Professional Standards Review Organizations within the areas of our nation and legislation which was responsible for the creation of the HSAs and the PSROs might just as well be repealed.

The complexity of the formula and the inherent request for exceptions in the proposed act will certainly require a huge bureaucracy complete with additional paperwork and thousands of inspectors, which in itself will increase the total health care costs of our nation.

A control program applied exclusively to hospitals may result in certain short-term savings to payers but in the end will be counterproductive to planned longterm objectives for restructuring the total health care system and will produce inefficient cost shifts to other provider sites.

Hospitals' Ability to Provide Services

Finally, and perhaps most importantly, a control of hospital finances will inevitably affect the hospitals' ability to provide services. The hospitals most adversely affected in this process will be those with the lowest current operating margins and reserves, that is, the most efficient hospitals. In the state of Montana, this includes literally every hospital for statistics show that while the adjusted expenses per admission for the total hospitals in the United States for the year 1975 was $1,030.49, the adjusted expenses per admission in Montana hospitals was $629.72, a tribute to the efficiency of operation of Montana's hospitals, both large and small. The application of the formula, which requires computations based upon the last two years' expenses will literally deny Montana's efficient hospitals even the 9% increase in charges.

Effects on Unemployment

Such a control program universally applied across the nation will force hospitals to cut back services by laying off professional personnel: nurses, dietitians, laboratory personnel, etc., just to be able to survive. A loss of professionals in a small community could quickly lead to the closing of the hospital and this would deny essential lifesaving services to Montana citizens who rely on all of their hospitals to provide these essential services. The fact that hospitals are now covered under unemployment insurance compensation laws will immediately increase the cost of hospitalization, which will increase the reimbursement paid under Medicare and Medicaid formulas.

ALTERNATIVES

Prospective Rate Reimbursement

For the past several years, the federal government has encouraged experimentation with a variety of new payment approaches. One of these approaches is based upon prospective rate reimbursement through rate review and the eventual approval of charges method within each state.

The Montana Hospital Association created an independent private corporation in 1970 currently referred to as the Montana Hospitals Rate Review System. This sytem is truly independent in nature and currently has no domination by either the individual hospitals, the Montana Hospital Association or state government. It operates on the principle of approval of charges sufficient enough for each individual hospital's operations and success in providing quality service. Built into the system is the philosophy of negotiations with the individual hospital in the event the charges requested are too high or would increase the "profit" of the hospital above a recognized norm. We recommend the establishment in every state of a rate review system wherein the hospitals either voluntarily or are mandated by state law to participate in a review as a true program of cost and charge justification to the people.

We recommend the continuance and support for the development of an effective health care plan in each state through the auspices of the Health Systems Agencies under Public Law 93-641. As a further recommendation, we request that P.L. 93-641 with minor amendments be extended for at least an additional year.

We recommend that the Professional Standards Review Organizations be encouraged to expand their programs to provide peer review of physicians' services in the physicians' offices as well as in hospitals and nursing homes and that the Professional Standards Review Organizations be given sufficient money to establish monitoring programs to weed out the incompetent physician and physicians who are conducting their activities in a fraudulent manner.

The goal of any system of paying hospitals for services must be to maintain fiscally healthy institutions that are needed to provide readily accessible care of a quality nature and a desired level of service in a reasonably efficient manner. It is in the public interest that hospitals never compromise this goal and it is for that reason that the Montana Hospital Association must vigorously oppose the Administration's bill as inappropriate in concept, unfair to the citizens of the state of Montana, too costly to be implemented and unreasonable in its approach to establish price controls on one segment of the economy without establishing wage and price controls on the other segments of the economy and in the end, the danger of actually increasing the total health care costs in the nation beyond the goals established by the federal government.

Thank you for your consideration of this testimony.

Statement submitted by: William E. Leary
Executive Vice President
Montana Hospital Association
P.O. Box 5119
Helena, Montana 59601

June 17, 1977

PREPARED STATEMENT

OF

NATIONAL ASSOCIATION OF HEALTH SERVICES EXECUTIVES

ON THE

HOSPITAL COST CONTAINMENT ACT OF 1977

(S.1391)

PRESENTED TO

SENATE SUBCOMMITTEE ON HEALTH

COMMITTEE ON LABOR AND PUBLIC WELFARE

This country's voluntary, community hospitals and public institutions -- "hospitals of commitment" -- have been the only health care institutions primarily serving the poor and disadvantaged populations of inner city communities where the need for concentration and application of health resources is the greatest, but where in reality committed resources are least likely to be found. Over the past two decades, more and more of our health dollars and resources have gravitated toward the more affluent, suburban and highly sophisticated, technology - oriented medical centers, leaving a dearth of quality delivery systems in the inner-city, creating virtual health care wastelands. If it were not for the fact that most of these institutions are managed and controlled by individuals who are themselves representative of the socioeconomically disadvantaged populations they serve, and therefore intimately aware of and sensitive to their plight, one would shudder indeed at the thought of just what kind of health care would be available without them. The commitment and mission of these individuals and institutions represent the last vestige of the fast eroding principle that health care is a right -- not a privilege. Accordingly, with budgets and revenues dependent upon the vagaries of the fiscal crises of our cities and uncertain sources of payment, these institutions, out of necessity if you will, have exercised the utmost constraint in containing costs. Perhaps it would be best first to examine the scenario in which these institutions operate in order to elucidate how their plight will be intensified by the imposition of the prospective cost containment controls of S. 1391.

The health status of minorities and inner-city residents is generally far lower than that of the population as a whole: the infant mortality and morbidity rates are much higher for nonwhites than whites. This phenomenon is merely a manisfestation of the inaccessibility to primary care by inner-city residents, attributable to a lack of sufficient numbers of primary care physicians. Blacks' and other inner-city residents' first interaction with

the health care system is in the emergency rooms of these institutions, due to the fact that persons who have limited incomes or who are not covered by insurance or some form of medical assistance are relegated to the position of having to enter the health care system as a last resort rather than interacting with it on a continuing basis. They tend to use the emergency room as a substitute for the physician's office thereby further complicating these institutions' financial problems; for insofar as identifying a hospital's highest "cost" center is concerned, the emergency room represents its greatest deficit operation. Accordingly, in performing their role of serving the "medically indigent," more of their resources are committed to nonreimbursable services. Moreover, again due to their low health status, and tendency to enter the health care system at the crisis stage, these patients require longer lengths of stay than those in other institutions because of the advanced stages of their respective diseases and illnesses. Accordingly, on a per admission basis, more of the hospital's limited resources are committed for longer periods of time to treating these types of patients — which results in a distorted view of their cost effectiveness and efficiency when one examines their discharge rates.

Furthermore, the propensity of physicians to practice "defensive medicine" due to the increasingly high incidence of malpractice claims has created and compounded utilization problems: those inner-city patients with sources of payment, who otherwise would enter community and municipal hospitals because of their proximity and accessibility, are being admitted to suburban and other institutions which have a wide array of sophisticated diagnostic equipment, supportive services and manpower. Unfortunately, the ironic byproduct of this situation is that these institutions invariably reject those nonpaying patients who are in greatest need of acute care, forcing

community and municipal hospitals to bear the burden of treatment, which themselves suffer from manpower maldistribution problems and lack of basic resources to deliver quality, primary care. In addition, until such time as permanent reforms of providing more extended care, home health, ambulatory care, and subacute care facilities and services in inner-city communities are instituted, there will be a need for greater inpatient utilization of these institutions.

VOLUNTARY, COMMUNITY HOSPITALS AND PUBLIC FACILITIES SERVING THE POOR AND DISADVANTAGED SHOULD BE EXCLUDED FROM THE PROVISIONS OF THE BILL

TRADITION OF "COST CONSCIOUS" MANAGEMENT

Since most of these institutions are managed by individuals who are themselves representative of the socioeconomically disadvantaged populations they serve, intimately aware of the needs of their user populations (good, basic primary care) and out of necessity over many years due to limited resources have been "cost conscious," the argument that hospital managers need more incentives to contain costs is least applicable to these institutions as a whole.

THE PRESENT ELEMENTS OF BASE YEAR COSTS WILL IMPEDE AND INHIBIT THE ABILITY TO PROVIDE BASIC SERVICES

These institutions, characterized by old physical plants and lack of modern,

basic equipment and supportive services, still need to "grow" and "expand" to the extent of achieving parity with the "model" inner-city facility that serves the needs of its community. Depreciation and related debt service expenses are now minimal, thereby forming an artificially and unrealistically low cost base which these institutions will be "locked" in to, creating the anomalous situation of their being penalized when modernization and upgrading expenditures increase their costs beyond permissible levels (of the bill) -- an ironic result indeed in light of their mission and purpose.

RANGE OF ADMISSIONS LOAD CORRIDORS IS TOO RESTRICTIVE AND WILL PENALIZE INCREASED UTILIZATION

Assuming that the dynamics of census levels of these institutions will change due to some fundamental changes and reordering of priorities grounded in such considerations as accessibility, alleviation of manpower maldistribution problems and realization of the proper role and function of these institutions, greater utilization will be penalized by the restrictive range on increased admissions; and the administrative burdens attendant thereto outweigh the accommodating intent of the exceptions provisions for "exceptional changes" in patient load.

STABILIZING REMUNERATION WILL IMPEDE ABILITY TO RETAIN AND ATTRACT HIGHLY QUALIFIED MANAGEMENT PERSONNEL

The remuneration of management of these institutions would be locked in to

much lower ranges than presently exists in other institutions when there is a need, in light of the adversity and difficulty in running these institutions, to retain and attract highly capable management personnel.

Respectfully submitted,

NATIONAL ASSOCIATION OF
HEALTH SERVICES EXECUTIVES

National
Audio-Visual
Association, Inc. 3150 SPRING STREET · FAIRFAX VIRGINIA 22030 · (703) 273 7200

July 7, 1977

Senator Edward M. Kennedy
Chairman, Subcommittee on
Health & Scientific Research
431 Russell Senate Office Building
Washington, D.C. 20510 Attn: Stuart Shapiro

Dear Chairman Kennedy:

With respect to your Subcommittee's work on hospital cost controls, may we suggest that hospitals be given a credit or special incentive to continue or expand their patient education programs?

During recent years, hospital administrators have recognized that increased education for the patient and his or her family can help reduce repeat trips to the hospital and can help avoid unnecessary medical expenses. In addition, patient education using audio-visuals is very important for communicating with non-English-speaking patients and for dealing with patients with low literacy who are unable to read the pamphlets and other printed materials available. Patient education involving audio-visual methods can free key health professionals to attend to other patients. Thus, a good patient education system can relieve one-on-one demands which contribute to rising health care costs.

Furthermore, hospitals have developed in-service training programs designed to (1) avoid loss of staff to faraway training facilities and (2) increase their efficiency and effectiveness in running the facility frugally. These programs involving the use of audio-visual communications are very successful.

Medicare, Medicaid, Blue Cross/Blue Shield and insurance companies have recognized the importance of patient education as a long-run way of keeping costs down. Almost all third party payers allow patient education as a normal hospital cost which can be charged as a portion of each medical reimbursement.

Our fear is this: If hospitals are asked to lower costs to comply with a "cap," as proposed by Secretary Califano, they may cut out some of the things which, in the long run, would help reduce overall costs. In other words, under a budget crunch, hospitals may make reductions in areas which can be easily cut, regardless of the long-run value of these areas as agents to cost controls.

Therefore, we urge your Subcommittee to consider incentives to hospitals which maintain patient education and staff in-service training on the grounds that both of these activities will, in the long run, contribute to lower costs and higher efficiency in administration.

You may wish to include this recommendation as part of your hearing record. Meanwhile, we would be pleased to discuss this idea with you or your staff. We wish to be of every assistance in the work you are doing.

Sincerely,

Kenton Pattie
Vice President and
Educational Director

KP/na

National Conference of State Legislatures

Office of State Federal Relations

444 North Capitol Street, N.W. 2nd Floor Washington, D.C. 20001 202/624-5400

President Martin O. Sabo Speaker of the House Minnesota

Executive Director Earl S. Mackey

July 27, 1977

The Honorable Edward M. Kennedy
431 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Kennedy:

As the Senate Human Resources Committee begins its important mark-up of S1391 - The Hospital Cost Containment Act -- I would like to inform you of the concerns of the nation's state legislatures with respect to this legislation. For your information, I am enclosing a brief policy statement reflective of the National Conference's position adopted in March of this year.

Basically, the NCSL position is one of complete support for a national program of interim restraints on increases in hospital revenues. However, we believe that the program should be administered at the federal level only up to the time at which a State enacts and implements an effective hospital cost containment program consistent with certain minimum federal guidelines. Furthermore, we suggest that the most appropriate roles for the federal government in this area are to provide start-up costs for the State programs and to monitor the State systems to assure they are meeting the goals of the national program.

Our position grows out of the conviction that a considerable amount of experimentation and evaluation needs to be done before we discover what cost containment system or systems are most effective. Naturally, we believe that the State level is the most appropriate governmental level from which to experiment and assess this particular kind of public policy issue.

For your information, The National Conference of State Legislatures is the only national organization representing the interests of the nation's 7,600 state lawmakers.

Thank you for your attention.

Sincerely,

Martin O. Sabo

Martin O. Sabo
President
National Conference of State Legislatures

Enclosure

STATEMENT OF

THE NATIONAL CONFERENCE OF STATE LEGISLATURES

ON

HOSPITAL COST CONTAINMENT

The National Conference of State Legislatures commends the Administration's willingness and initiative to enact an interim program for restraining the unacceptable growth in hospital costs. Since hospital costs are the most rapidly rising component of health care costs and since they account for 45 percent of personal health expenditures, cost containment in the hospital sector deserves a high priority. Such an emphasis is particularly desirable because hospital care is the most expensive form of care; hence policies which encourage economizing on hospital services and substitution of other forms of care will almost certainly reduce costs of treatment.

The clear strategy of the Administration by the introduction of the Hospital Cost Containment Act is to provide something of a "dull meat ax" approach to containing hospital costs until a more sophisticated cost control system can be put in place. There is no dispute that a sensible cost control strategy or system must precede the implementation of a national health insurance program. Substantial disagreement is likely to occur, however, over what kind of cost control system will prove effective and what level of government should be responsible for administering and operating the system.

Given the fact that cost containment is still largely an art, not a science, flexibility and experimentation should be key to the eventual discovery of a system or systems that will function properly. The assumption that the solution to cost inflation in the hospital sector lies in a single approach is a faulty one and, if allowed to guide our policy, is likely to lead us into a system of extreme rigidity and inequity. The NCSL is therefore concerned that the present bills fails to provide real incentives for states to develop alternative hospital cost control programs within the parameters of reasonable revenue restraints. Recognizing that the development of sound regulatory controls on hospital costs is still in its infancy, states should be encouraged to experiment with several approaches of combinations of approaches to hospital cost control within the context of minimum federal criteria. NCSL is worried that the Administration's bill as presently drafted would set a precedent for precluding states from meaningful participation in hospital reimbursement policy under a national health insurance program. It is essential, therefore, that the bill be amended to allow interested states some opportunity to develop alternative state-wide hospital cost containment programs.

An Alternative Proposal

In arriving at an alternative proposal -- or perhaps an amended version -- to what the administration has developed, NCSL wishes to acknowledge it has borrowed some ideas from an excellent report entitled, "A Proposal for State Rate-Setting: Long Range Controls on the Cost on Institutional Health Services." This model state rate setting proposal is the product of the Government Research Corporation, a private, non-profit organization engaged in research and policy analysis. While NCSL does not embrace every specific recommendation embodied in the document, we feel that its major thrust, namely, the encouragement of state rate-review and rate-setting programs is highly preferably to the complicated and inflexible regulatory system that would likely evolve at the federal level under the administration's program.

The National Conference of State Legislatures endorses a federal initiative of interim restraints on increases in hospitals' revenue, applicable to each state until that state enacts and implements an effective hospital cost containment program. Once the state program becomes operative, the Department of HEW should monitor the state system and be prepared to assume the functions if it is clear the state is not performing effectively.

While each State ought to enjoy considerable flexibility in determining its own specific structure and the methodology it will apply in controlling hospital revenues, certain broad characteristics of an effective State hospital cost containment system can be suggested:

- Budget and rate review and approval should be mandatory for all institutional health care providers and shall apply to the rates charged to all payors;

- The budget and rate review authority should be either an independent commission or an agency located within an appropriate department of the state;

- The commission or agency should be organizationally related to other state agencies in such a way as to facilitate coordination of the various types of health care regulation.

- The commission or agency should publish a set of uniform definitions for all categories of cost recognized as subject to reimbursement, and for recognized categories of revenue adjustments;

- While a uniform financial reporting system should be required of all institutional health care providers, each state commission or agency should determine its own needs and issue appropriate regulations with respect to uniform budgeting, accounting and cost allocation for institutional providers within its jurisdiction.

- The commission or agency should have discretion to prescribe one or more bases of payment for use by institutional providers. However, institutions should be prohibited from charging different payors according to different bases of payment.

- The commission or agency should be served by an advisory committee to consult on technical issues. The Advisory Committees' make-up

should be balanced between consumer representatives and health industry spokesman. While the Advisory Committee would assist the agency or commission in such activities as designing and evaluation reporting procedures and guidelines, it could serve an equally significant role in forging a communications link and sense of partnership between all concerned parties.

Aside from enacting an interim program of restraints on increases in hospital revenues which would be waived for states operating effective cost containment programs, Congress should be willing to provide financial assistance to states for the initial start-up costs of the hospital commissions. Consideration of state requests for medicare and medicaid participation in the systems should be given the most expeditious consideration by the Department of HEW. HEW should exercise a monitoring function to ensure that the state commissions are performing satisfactorily. A national policy review board should be created to establish guidelines by which the performance of the state systems will be measured.

The fact that states differ substantially in their political, economic and social make-up has grown to the level of a truism. Such differences, however, reveal why there is likely to be a variety of state responses to the adminstration's initiative. Some states will willingly step aside and welcome federal administration; others that have been regulating the hospital industry for some time will insist they can do a better job than the federal government. However, there remains a host of states that fall somewhere in between those two poles and they can best be characterized as certainly not having the best methodology for containing hospital costs but believing that the state level is the most appropriate level from which to experiment and evaluate this particular kind of public policy issue.

The case for state participation in hospital cost containment rests not only on the argument that states are good experimental "testing grounds'; many other arguments are equally compelling:

The protection of the citizenry's health has traditionally been within the recognized police powers of the state;

States shall continue to make large contributions to the health care system through medicaid and as purchasers of health care for state employees; therefore, they have a financial stake in the success of the program.

States are in the best position to view individual hospitals' needs, priorities, budgets, and operations in the context of statewide needs, priorities and resources for health care.

States can most easily assure the coordination of rate review and other forms of regulation, such as, certificate-of-need review.

There is no question that government must do more to stem the tide of cost inflation in the hospital sector and, to that end, the administration's proposal offers a useful starting point for discussion. Our concern is that government is too often synonomous with national government and the legitimate interests and capacities of other levels of government, namely state and local, frequently go unrecognized.

STATEMENT OF JOHN F. HORTY,

PRESIDENT OF THE NATIONAL COUNCIL OF COMMUNITY HOSPITALS,

BEFORE THE

SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH

COMMITTEE ON HUMAN RESOURCES

ON

S. 1391

JUNE 17, 1977

NATIONAL COUNCIL OF
COMMUNITY HOSPITALS

My name is John F. Horty. I am President of the National Council of Community Hospitals and serve as Chairman of the Board of one of its member hospitals. I greatly appreciate having the opportunity to appear before you to present the views of the members of the Council on S. 1391.

NCCH is an organization composed of not-for-profit, community hospitals located in 21 states throughout the United States. They include some of the best-known hospitals in the country. They represent a variety of sizes and types of hospitals, and all are dedicated to providing quality patient care to their communities.

Community hospitals provide the majority of hospital care in the United States. The members of the National Council of Community Hospitals, therefore, have a vital concern with S. 1391.

The Administration's Proposal

NCCH endorses the general intent and the objectives of the administration in sending to the Congress a proposal to restrain health care costs. We have long felt that such costs are rising at an unacceptable rate and that strenuous efforts must be made to change this trend. The administration's proposal is a serious effort to do so. We are pleased that this proposal is stated to be a transition step in the process of developing the structural

reform that is needed permanently to get a handle on costs.

Our difficulty with S. 1391 is that it is a transition in the wrong direction, or at the very least a transition in the same old direction, that of increasing regulation. It does nothing to aid structual reform nor does it give hospital management the tools to manage cost controls. It freezes the wrong part of the total system. It freezes management initiative through more regulation. It restricts management operating control. It is more likely to produce bad management decisions than good ones. And it may--or it may not--actually limit cost increases. It could just as easily be labeled the Quality Containment Act of 1977 or the Innovation Containment Act of 1977 as the Cost Containment Act of 1977.

Because NCCH recognizes that hospital costs cannot be controlled for any significant length of time unless the health care delivery system is changed, we began, more than a year ago, to develop a proposal to reform the health care delivery system in a way that would improve access, restrain costs, and free both government and hospitals from the bureaucratic control of practically every aspect of hospital operations that now prevails. S. 1391, however, does not aid in the process of developing structual reform.

S. 1391 is precisely the wrong bill at the wrong time because:

--It does not address, let alone alleviate, the problems that have caused the increase in health costs.

--It fails to provide hospitals with the tools necessary to contain costs.

--It puts into place an inordinately complex legal and administrative structure that can only impede efforts to develop necessary reforms.

Not only does it fail to address the real problems; if enacted it would sweep the necessary debate about these problems under the rug, and the "transition" could become the permanent system. A "transition" bill must force the next step toward an ultimate solution. This bill does not. The bill, in short, opts for a cap rather than a cure.

We object to the actual provisions of S. 1391, and even more basically, object to the conceptual framework of the bill. But as a proposal it does serve to open the dialogue. As law, however, it could close the debate for the foreseeable future. The members of the National Council of Community Hospitals strongly believe that the time has come to face all the problems in the field, not just costs. The members believe that costs are a symptom and that the question of fundamental

structural reform is the real question.

If no bill is enacted, the problem will not go away. It will continually reappear year after year, each time larger and more voracious, and the solutions offered will be ever more stringent, and more arbitrary. We therefore feel that we cannot merely oppose the administration's bill. We must in conscience offer an alternative proposal, one that we believe seeks to change behavior, and does not merely regulate.

NCCH's Cost Containment Proposal

We are, therefore, proposing for consideration a short-range cost containment program which, although very stringent to hospitals, would be preferable to the administration's proposal. It is preferable because it is simple and clearly temporary, and because it will assist in developing basic reforms. Our proposal will save approximately the same amount of money as the administration's bill, although saving money in the short-term is secondary to changing behavior in the health field so that the savings become permanent.

Our proposal specifically addresses the three criticisms that have been leveled at hospitals: over-staffing, over-building, and over-utilization. We do not think these criticisms are warranted to the extent portrayed, but our

proposal, if adopted, would allow an assessment of their validity.

I will describe our proposal in detail subsequently in my testimony. Before doing so, however, it is important to discuss why an alternative short-range proposal is necessary to advance system reform.

Cost Problems That Must Be Confronted

The problem in health care delivery is not, as Secretary Califano seems to believe, ineffective hospital administrators. In fact, hospital chief executive officers are highly trained and effective leaders who, with their boards of trustees and medical staff leadership, are today performing a difficult task under impossible conditions. The problem is the system under which hospitals are forced to operate.

It is time for the nation to address the fundamental weaknesses of the present system. We must consider the causes of increasing costs of medical treatment, not just the symptoms. But S. 1391 can open a meaningful dialogue on what reforms are needed only if the problem is seen in a somewhat less personalized and more conceptual manner than it was by Secretary Califano in his recent press conference. Putting the blame on hospitals and their managers does not contribute to an atmosphere in which the problems can be solved.

In our talks with administration officials, we have found them to be well aware of the problems facing the health care field. They recognize, as I believe members of this Committee do, that hospitals are only one of the participants that contribute to hospital costs. In order to achieve reform that will reduce costs on a permanent basis the practices of numerous participants in the health care field must be affected: hospitals, physicians, insurance companies, employers and employees who purchase insurance, Government, and even patients.

Administration officials know, for example, that hospitals have severely limited power when it comes to affecting physicians' practices. Only physicians have the authority to admit and discharge patients, and to determine the intensity and mix of medical treatment. What sort of patient is hospitalized, how many tests are given, and what sort of overall care is accorded are matters currently within the sole prerogative of the physician, who in large part makes these determinations free from hospital control or influence and without the need to consider economic factors.

Administration officials know that insurance companies have through the years engaged in intense marketing campaigns to sell more and more comprehensive insurance plans to cover

hospital stays. They know that organized labor has strenuously bargained for comprehensive health insurance plans for their union members and that these plans have made more and more hospital benefits available to more and more citizens. Moreover, they know that most patients have sufficient insurance so that the costs incurred during their individual hospital treatments are, at least in their minds, largely unrelated to the premiums that they must pay whether or not they are ill during the year. Patients, like their physicians, have no incentives under the present system to weigh the medical value of a particular service against economic cost.

And Government itself is a prime factor in increasing costs. It is symptomatic--and strangely ironic--that at the precise time the administration was setting forth its proposed Hospital Cost Containment Act, which is premised on limiting increases in admissions, it asked for an expansion of medical treatment for 800,000 children. If the administration's Child Health Assessment Act were enacted, it necessarily would result in many thousands of additional hospital admissions in the first year. NCCH strongly supports the administration's request, but we must point out that it, or any similar program, is totally inconsistent with a cost containment program. To couple the two programs in one message makes obvious the folly of attempting to control costs by putting caps or lids on the present system.

Weaknesses of S. 1391

The fundamental consequences of S. 1391 are readily apparent: The bill will subject hospitals to an incredibly complex administrative process. A cadre of officials in government and in the health care field will proliferate and a state of mind will develop that could result in the concepts of the bill becoming a permanent fixture on the health care scene. Through Title II, the bill will politicize the distribution of hospital construction funds. It will delay the true reforms that are urgently needed.

We will not comment at length concerning the weaknesses of the present bill. Some of them are listed below and the reasoning is contained in the Appendix to this testimony. Neither will we offer technical changes to S. 1391 at this time. Tinkering with the details of the bill will not cure its conceptual weaknesses: While a straitjacket can be tailored to look like a tuxedo, it will still retain the constrictions of a straitjacket; it can only be used to restrain the patient forever while he is forgotten.

Our specific objections to S. 1391 are as follows:

1. The bill totally fails to address the major problems causing high hospital costs.

2. The bill is so complicated, its effects so uncertain,

and its penalties so confiscatory that it will freeze all initiative and all management risk-taking in the hospital field.

3. The bill unfairly penalizes already efficient and well-managed hospitals.

4. The bill unfairly penalizes hospitals that have already expanded, are expanding or are committed to expand, as well as those which are continuing to increase services and admissions to meet community needs.

5. The bill discourages consolidation of duplicate facilities.

6. The bill encourages expansion of duplicate equipment and services in physician's offices, clinics and nursing homes by not putting restraints on this proliferation of uncontrolled capital expenditures.

7. The bill contains no adjustment for changes in intensity of service or changes in patient mix.

8. The bill politicizes the planning process in the allocation of capital funds.

9. The bill impedes the restructuring of the health system needed in anticipation of national health insurance rather than facilitating it.

10. The GNP deflator is not an effective tool for measuring the impact of inflation of goods and services required by hospitals.

11. The bill unfairly applies a cap individually on revenues from each class of payer.

12. The bill's base period refers to a period that is unrealistically long ago.

13. The bill contains virtually no exceptions procedure.

14. This "temporary" bill contains no expiration date.

15. The bill unfairly penalizes hospitals for increases in bad debts and free care.

Explanation of NCCH Proposal

We believe a cost control program must be simple, not complex. We believe that by their very nature controls are arbitrary, not equitable, and consequently that any control program must be of strictly limited duration. Such a plan must be self-executing, devoid of clanking administrative machinery. More importantly, it must be a step to the future. Accordingly, we propose the following program (the terms of which are interrelated and nonseverable):

-- (1) a freeze on hospital employment for 24 months;

-- (2) a freeze on capital expenditures for 24 months; and

-- (3) sanctions that would cause physicians to comply with PSRO and Utilization Review strictures on admissions and length of stay.

The hospitals that are members of NCCH offer this alternative plan and are prepared to make it work. We are prepared to do so without any reduction in the quality of care during the 24-month freeze. No seriously ill patient will be deprived of care and treatment in our hospitals. The boards of trustees, medical staff leadership and management of hospitals are not only dedicated but talented, and can continue providing quality care during such a temporary freeze.

We believe that community hospitals, of all hospitals, are the ones best suited to call for this effort, for they have a proud tradition of service to their communities and no motives, imperatives or purposes other than that service. That many are religious in origin and operation only underlines this dedication.

NCCH membership represents a cross-section of big and small hospitals with varieties and mixes of service. They are not likely to have identical economic interests or to be affected identically by our proposal. They are, however, united in their desire for a change in the present system of reimbursement and delivery of care and are willing to take the risks a temporary freeze would entail, <u>if</u> what emerges at its termination is better than what exists now. We believe many community hospitals not members of NCCH will agree.

We believe permanent changes must and can be made through a cooperative effort involving the Government, the American Hospital Association, the American Medical Association, the American Osteopathic Association, the American Nursing Association, consumers, insurance companies, labor, industry and other interested groups. The time is ripe for this effort. We believe that the present moment could well be a decisive one in the history of the hospital field, and its relationship with Government. We may have one last opportunity for cooperative effort. We wish to seize this moment.

We make this proposal not because we desire controls but because we desire to work for constructive change of the system that will result in less, not more, regulation, and we believe that this 24-month period will give us and the Government the breathing room necessary to do so. We will hold the system together for 24 months while all the concerned groups I referred to work jointly on a suitable long-term plan. We are seeking to develop a cooperative effort, not a coercive one -- one that will result in a plan that hospitals can accept, not one that is imposed.

We believe that, in the long run, the patients of American hospitals will be better served by a temporary freeze on capital growth and increased labor intensity than by a mechanism which permits the Government to

determine which hospital can buy which piece of equipment. We believe that in the long run these decisions can be made only by patients and hospital management, including boards and medical staff leaders, not by the Government, and we do not believe structural reform is served by contributing to the assumption that a few bureaucrats can determine what resources should be spent by what institution for what purpose.

Our proposal, while restrictive in the short run, will, we believe, set in motion forces that will enhance the public's participation in determining the future of the health care system rather than delegating the decisions to a handful of Government officials. We believe our proposal will force the Government and the American public to face the real issues involved in health care delivery. Consequently, we believe that the short-range sacrifices our proposal would entail are better in the long range than the sweep-it-under-the-rug approach of the administration's bill or any approach that nibbles quality to death so slowly that we only know it is gone when it is too late.

Against that background, let me amplify our proposal:

1. Freeze on labor intensity

All hospitals, of whatever type, would be prohibited by statute from increasing their ratio of full-time equivalent employees (FTE) per inpatient day in excess of that

experienced during the twelve-month period ending May 1, 1977.

The number of full-time equivalent personnel (FTE's) in nonfederal short-term general and other specific hospitals has increased at about five percent per year on the average over the 1966-1975 period, and at a slightly higher rate in 1976, based on AHA data (Hospital Statistics, 1976 Edition for 1966-75 data).

The number of FTE's per one hundred daily census increased at about 2.9 percent per year, 1966-75 (and at about that rate in 1976) based on AHA data. NCCH proposes a restraint on hiring in terms of maintaining a constant employee-to-average-daily-census ratio. Holding the ratio of FTE's to daily census constant would save about $785 million in the first year.

Under our proposal, the base period would be adjusted to exclude from it FTE's associated with an element of service that was performed by the hospital itself in the base period, but may no longer be during the freeze.

Any excess over the permitted personnel would subject the hospital to severe financial penalties.

Our freeze on labor intensity would save large amounts of money. It would also relate personnel levels to patient needs as the administration's bill fails to do. The administration's bill would require a reduction in labor force

per patient day if admissions increase -- which, of course, would adversely affect patient care. Conversely, the administration bill would permit hospitals with declining census (if the decline does not exceed 6%) to increase the number of their personnel in proportion to admissions -- an inequitable and costly loophole. Our proposal, on the other hand, would force a hospital not to increase the current intensity of labor. If admissions increased or decreased from the base period, the labor force would have to be adjusted to reflect these changes. Thus, quality of care would not be adversely affected, as it could be under the administration's bill, with increasing admissions. And labor intensity could not be increased with declining admissions.

2. Freeze on capital expenditures.

From the date of enactment, all capital expenditures, including lease transactions, for new or expanded health care facilities or equipment, by whomever made, would be prohibited. The only exceptions to this moratorium would be those capital expenditures (i) for which a legally binding commitment has been entered into or planning approval obtained before May 12, 1977, (ii) which relate to maintenance and repair, or replacement of irrepairable equipment, and (iii) which are required by a Government or certification agency, such as safety equipment required by OSHA.

The sanction for making capital expenditures in violation of this moratorium would be civil penalties in an amount equal to twice the prohibited capital expenditure.

This freeze would save approximately $900,000,000 in the first year.

3. Strengthening peer review.

A mechanism would be instituted to provide that when a hospital admission or portion of a hospital patient stay is found upon PSRO or Utilization Review to be unnecessary, the responsible physician's reimbursement would be reduced by the same percentage as the hospital's compensation is reduced by the improper admission or unnecessarily long stay.

Long-Range Implications

We believe that Medicare, Medicaid, Blue Cross, Blue Shield, the Planning Act, PSRO's, Utilization Review, rate review, reasonable cost, prudent buyer -- in fact, all these reimbursement and regulatory mechanisms -- have become so ponderous, so freighted with constraints, so complicated, so inconsistent -- in short, the present system is so flawed -- that very little can be done to reform the structure while retaining them. It is time to call a halt.

To borrow half a phrase from the administration, it is time for "zero-based regulation program" in this field.

The administration's proposal adds to the present base of regulations; it builds upon them; it does not question them. We do. Hospitals are tired of being told how to run their business and then not allowed to run it.

In effect our proposal takes the form of a contract between us, the management and leadership of hospitals, and the Government and other interested groups. We will hold the system together for 24 months and no longer in a no-growth situation -- while rational restructuring is developed. We will participate constructively in the process if the debate does not assume the existence of the present system, if the search for less not more regulation is a genuine one, and if there is agreement that there is a need to rationalize the system, without any assumption that rationalization necessarily entails intimate Government involvement. We must go back to first beginnings.

Our proposal would save approximately the same amount of money as the administration's bill. But it would not require a complicated legal structure. Its simplicity is an advantage in itself. More significantly, it would avoid creating the delusion, as the administration's bill may, that a complex cost-control mechanism is a first step toward structural reform.

Our proposal would quickly catalyze a national debate on the structure of the health care delivery system. It is far more likely than is the administration's bill to promote the development of truly basic changes in the system. Our proposal would encourage the development of features and behavior that we believe are essential components of structural reform. It would give hospital administrators and boards more power to manage their institutions than would S. 1391: within the strictures set by our proposed freeze, they would be free to allocate resources as they determine is best for the patients and the communities they serve. And our proposal would put a brake upon the constantly growing intrusion of the Government into the management of health care delivery.

It may appear ironic that a group of hospitals is forced to propose its own system of controls as a means of reducing controls, but this is a reflection of the absurdity of the current system.

I thank you for the opportunity of appearing before you today.

APPENDIX

Explanatory Comments on S. 1391

1. The bill totally fails to address the major problems causing high hospital costs.

The bill attacks the symptoms of the problem, rather than the structural conditions themselves. It leaves the physician and the patient free to determine medical services without being required to consider economic factors. It imposes the cost burden of physician practices on the hospital, while doing nothing to augment the hospital's ability to affect those practices. It provides no award for management efficiency. It fails to consider that hospitals are only one component in what is now a disjointed non-system of health care, and provides no mechanisms for rationalizing the contributions of the component parts. It does not contribute, and indeed impedes, structural reforms.

2. The bill is exceedingly complex.

The bill, while advertised by the administration as an uncomplicated method of imposing controls, is actually highly complicated in concept and operation. Its effects are uncertain and difficult to measure, and its enforcement so confiscatory that it will freeze desired initiative and management risk-taking in the hospital field.

3. The bill unfairly penalizes already efficient and well-managed hospitals.

Hospitals which have no fat in their budgets and are already well run will be unfairly penalized since they have nothing left to cut. The "obese" hospitals with which Secretary Califano was concerned in his press conference of April 25, 1977, will have no difficulty in complying with the requirements of the bill and may well remain "obese," even if less so than before. The well-managed, innovative hospital will lose to the "status quo" institution. Moreover, the bill fails to distinguish the "fat" in hospitals that hospitals can control from that which they cannot control. The fat caused by excessive tests (if excessive can be defined), for example, is solely within the prerogative of the physicians. Increases in intensity are covered in the bill solely with a three percent differential between the GNP deflator and hospital expenditures, and this differential is designed to shrink progressively the longer the control period lasts. Yet physicians are nowhere required to freeze intensity increases to three percent.

4. The bill unfairly penalizes hospitals that are expanding revenues and services and rewards less efficient and declining hospitals.

The bill's treatment of a hospital with a growing number of admissions is unfair and unrealistic.

The bill accords hospitals no means of controlling the number of admissions if they are considered necessary by the admitting physicians, but would penalize hospitals for those increasing admissions.

The bill would preclude a hospital from collecting any additional revenues when its admissions increase in any class of payer by two percent. A hospital thus would be in violation of the revenue limitations set forth in the bill if it experienced a small change in admissions (a change that is difficult to measure until year end) and had the temerity to seek payment for those admissions.

Furthermore, by allowing hospitals only one-half of the revenues associated with increases in admissions between 102% and 115% of the base, the bill requires hospitals to lose money on those admissions.

By providing that no revenue can be collected for admissions in excess of 115% of the base year admissions, the bill prevents a hospital from being paid for any of the operating costs incurred in treating those patients. Thus, a new manufacturing plant could have been built in a town within the last eighteen months and the town's hospital experienced increased admissions. But the hospital would be prevented from being paid for caring for those patients. Moreover, a hospital that has expanded to serve that increased

use would be prevented from being reimbursed for the costs associated with the expansion if they were not reflected in the base period. The bill makes the implicit and highly unlikely assumption that increases in admissions can be achieved with the existing physical plant and equipment.

Similarly, the bill ignores expenditures that the hospital has committed to make after the base period, which may increase the hospital's capacity to serve additional patients. By ignoring these expenditures, the bill penalizes a hospital for merely experiencing a planned increase in admissions.

By applying controls to each class of payer, the bill would require a reduction in revenues pursuant to the "admission load formula" if admissions within a class increase, even if the hospital's total admissions remain static or decline.

Growth is necessarily cumulative, but the bill maintains a fixed base. Thus, if a hospital grows by five percent in each of three successive years, the hospital would be prohibited from collecting revenues for any additional patients.

5. The bill discourages consolidation of duplicative facilities.

While most knowledgeable persons in the health care field believe that consolidation of duplicate services is beneficial, the bill would penalize, and thus deter, consolidation. It would disallow increased revenues resulting from consolidation since, as discussed in connection with Comment 4, above, it prohibits a hospital from being reimbursed for the resulting "growth."

6. The bill encourages the purchase of capital equipment by doctors and other exempted providers.

The bill encourages expansion of duplicative equipment and services in physicians' offices, clinics and nursing homes. By placing stringent restraints on capital expenditures by hospitals, the bill encourages the entrepreneurial physicians, nursing homes, and other exempted facilities to invest in medical equipment which the expenditure cap prevents a hospital from acquiring. While this is a problem under the current system, the cap on capital expenditures markedly heightens the opportunities available to non-hospital providers for financial gain while controls last. This loophole will work to the serious detriment of long range reform.

7. The bill contains no adjustment for changes in intensity of service or patient mix.

While changes in intensity of service and patient mix occur from year to year, the bill includes no adjustment for such changes which would allow the hospital to adjust its base period to reflect true comparability between the base period and the type of services presently offered by the hospital. After a lapse of time under the bill, types of treatment offered by the hospital and the nature of its patients may be substantially changed from that of its base period. Yet, by using a fixed base period and by failing to include an adjustment for mix and intensity, the bill sentences the hospital to a comparison of "apples and oranges."

8. The bill politicizes the planning process in the allocation of capital funds.

In effect Title II assumes that the planning process, which has only recently been instituted, cannot work. It all but eliminates community discretion and corresponding pride--a reservoir of strength in the current system.

Title II is inconsistent with Title I, which excludes out-patient services from controls. Title II would include in the expenditure limitation the capital expenditures necessary to implement increased out-patient services.

Moreover, we fear that the method of allocating funds will further politicize the planning process to the detriment of hospitals in sparsely populated or less influential areas. If an overall cap is to be placed on capital expenditures, NCCH believes that this should be done on a hospital-by-hospital basis pursuant to a statutory formula, and that the Secretary should not have the power to allocate capital expenditures among the states, nor should the Governors have that power within the states. We do not believe the patients of this country will be served by giving the Secretary or Governors the power to determine which community obtains a piece of the shrinking capital pie.

9. The bill impedes structural reform.

The bill impedes, rather than facilitates, structural reform. It focuses only on hospitals and ignores all the other participants in health care delivery. It would put into place a complex system of regulation that cannot be the basis of structural reform, but which some persons may mistakenly attempt to transform into a long-range program. It discourages consolidation of facilities (see comment 5, above) and indeed it provides a financial incentive for providers other than hospitals that are exempted from controls to assume hospital services.

10. The GNP deflator is not an effective measuring tool for hospitals.

The GNP deflator, which is used as the basic measuring rod in the bill, is a nationally derived number and does not take account of regional differences in the rate of inflation. Moreover, the shrinking difference built into the bill between the GNP deflator and allowable revenue increases fails to take account of the reasons that hospital cost increases were higher than the GNP deflator in the first place.

11. The bill unfairly applies a cap individually on each class of payer.

The bill would subject hospitals to a cap on each class of its payers. A "typical" hospital will have at least four classes: Medicare, Medicaid, Blue Cross, and commercial insurance companies-charge payers. The separate limitation chosen by the administration for its "simplicity" would apply separately to each and would force each hospital to make a complicated computation for each class.

The administration has failed to recognize that many patients cannot easily be categorized in one compartment. One patient could be covered by Medicare, Medicaid and supplemental commercial insurance for one admission. Yet the adminstration's "simple" approach would require the hospital somehow to divide the admission into its various segments for purposes of applying the cap.

In addition to the severe administrative burdens this would impose, the proposed system could, for no discernible policy reason, present severe financial difficulties for the hospital. It assumes that a hospital's proportion of patients (or revenues) from each class will remain the same. They will not. If a hospital's mix of payers shifts as between paying patients and Medicare or Medicaid patients so that Medicare and Medicaid patients constitute an increased percentage of the hospital's admissions, the hospital would receive less revenue. Medicare and Medicaid do not pay their full share. At the present time, the hospital is forced, despite the protection supposedly provided by Section 1861(v)(1)(A)(i) of the Social Security Act, to recoup the shortfalls incurred in serving Medicare-Medicaid patients by increasing the amount collected from other payers such as Blue Cross, commercial insurance companies and full-paying patients. But if a hospital's proportion of Medicare-Medicaid patients increases, or if Medicare-Medicaid continue to reduce the amount of their reimbursement, S. 1391 would severely impair the hospital's ability to collect the deficit from other payers.

What would happen if a city hospital closed? The proportion of Medicaid patients in the remaining hospitals would increase, perhaps in excess of the permitted limit. Or if a company changed its health coverage for its employees from a

commercial carrier to a cost-paying plan, the local hospital's limit for cost payers could well be exceeded.

12. The base period starts unrealistically long ago.

The base period proposed is unrealistically removed from the present. By choosing a base period for the fiscal year ending in calendar 1976, a hospital's limitation could be computed by reference to a year that ended as long ago as January 1976 -- ancient history even if the bill is enacted by October 1977.

Under the method prescribed in the bill, even if a hospital's costs increased by more than 15 percent prior to the effective date of controls (a quite common increase given the national average) the "adjusted inpatient hospital revenue increase limit" may reflect no more than a 15 percent increase. This will require a rollback for many of the nation's hospitals. Increased admissions since the base year create similar problems (see comment 4).

13. There is virtually no exceptions procedure.

The bill's exception procedure fails to address any of the flaws contained in the bill. The procedure would allow only the most financially troubled, insolvent hospitals to obtain relief and then only enough relief to allow the hospital to attain a hand-to-mouth level of minimum financial capability and not to restore financial stability. The system, we are afraid, is designed to bring hospitals

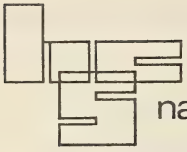
to their knees and to ensure they stay there under the control of the Secretary.

14. The bill contains no expiration date.

While the bill is advertised as a temporary measure, the bill significantly contains no expiration date. Without an expiration date, the pressure for structural reform will inevitably be deferred to a distant date, and the field is likely to limp from year to year under an unsatisfactory and inequitable system of controls.

15. The bill penalizes hospitals for increases in bad debts and free care.

The bill applies to gross revenues. Bad debts and free care therefore will be charged against the hospital's allowable revenues as if they represented real revenues, when in fact no revenue is realized. An increase in the percentage of bad debts or charity patients could cause a hospital to be out of compliance if, as would be necessary, it increased its revenues to recoup the costs associated with these additional nonpaid charges.



national COUNCIL OF HEALTH CARE SERVICES

STATEMENT

OF THE

NATIONAL COUNCIL OF HEALTH CARE SERVICES

SUBMITTED TO

THE SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH

OF THE

COMMITTEE ON HUMAN RESOURCES

UNITED STATES SENATE

ON THE SUBJECT OF S.1391

MAY 26, 1977

Mr. Chairman Kennedy and Members of the Subcommittee:

On behalf of the National Council of Health Care Services, I would like to express our appreciation for this opportunity to submit our comments on S.1391.

The National Council represents a select group of proprietary, multi-facility nursing home firms. Members of the National Council own and/or administer more than 80,000 beds in long term care facilities throughout the country. Its member firms are also involved in other health-related services, such as hospitals, psychiatric facilities, rehabilitation centers, and day care centers.

First, we would like to express our strong support of the concerns expressed by President Carter, and the Members of Congress regarding the need to contain the increases in the cost of health care in this country.

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In regard to the specific percentage ceilings outlined in S. 1391, we are concerned that this approach to containing the increased cost of health care may create more problems than it solves. Senator Herman E. Talmadge, Chairman of the Subcommittee on Health of the Senate Finance Committee, on May 5, 1977, outlined succinctly the four major possible problems with the flat percentage ceiling approach. He stated that

> "My uncertainty over the wisdom of a cap on hospital revenues stems from a series of concerns:
>
> "First, that a cap may become a floor;
>
> "Second, that with all the exceptions, the cap may be ineffective as a ceiling;
>
> "Third, that a cap by its very nature is arbitrary and tends to penalize those who have been efficient in the past and reward those who have been inefficient; and
>
> "Fourth, that switching from our current control mechanisms on reimbursement to a new concept of a cap for one or two years, and then to yet another control concept as embodied in my bill, may cause such chaos within the hospital field as to cancel out the dubious savings involved."

These points are, in our opinion, valid and need to be very carefully analyzed before the adoption of the type of percentage ceilings delineated in S. 1391.

In addition to the problems of applying such ceilings to hospitals, we would view an extension of them to nursing homes as being extremely inappropriate at the present time. This opinion is based on two factors.

A. First, based on statistics which are currently available from the National Center for Health Statistics of the Department of Health, Education and Welfare, the average number of patients being served

daily in nursing homes increased from 1967 to 1976 by approximately 756,000 to 1.3 million, or a 72% increase. During the same period, the average daily patient census in hospitals increased by just over 100,000, or approximately 14%; while hospital expenditures increased by approximately $38.3 billion, compared with $8.9 billion in nursing homes. From this, it is clear that the major cause for the increase in nursing home expenditures has been the 72% increase in the number of patients.

There have been, in addition to the enormous increase in patients, several other factors which have contributed significantly to the increased expenditures in nursing homes. For example, we would call your attention to the legislation and regulatory changes in facility and eligibility standards under the Medicare and Medicaid programs, as well as minimum wage increases.

In regard to the changes in the Medicare and Medicaid programs, major legislative revisions in 1969 and 1972 resulted in new regulatory requirements which caused significant increases in capital and operating expenditures by nursing homes to meet the new standards. These increases have been documented in studies conducted for HEW, with the most recent one conducted by the JWK International Corporation, entitled "Assessment of Cost and Operational Impacts of Skilled Nursing Facility/ Intermediate Care Facility Standards". Without question, these changes in standards have improved the quality of care, however, we would merely point out that they have also resulted in increased expenditures for nursing home care.

As for minimum wages, in 1967, the minimum wage for nursing home employees was $1.40 per hour, and in 1976, it was $2.20 per hour; or an increase of 57%. The importance of this increase becomes self-evident, when you consider that approximately 40% of the approximately 700,000 employees fall into a wage classification at or just above the minimum wage, thus a 57% increase has had a sizeable impact on the industry. The impact of increases in employee wages would continue under the provisions of S.1391, in that expenditures for the wages of these employees would fall into the classification of "non-supervisory personnel" which would be exempted from the restrictions of the Bill. Therefore, this particular pressure on increases in expenditures would continue to exist under the proposed legislation, if applied to nursing homes. Again, we by no means object to this increase, but rather point out that it has contributed to the increases in general of nursing home expenditures.

When considering these three preceding factors, as well as the general rate of inflation in the country from 1967 through 1976 of 6.1% annualized, we would suggest that it is not unreasonable that we have experienced an increase in nursing home expenditures of $8.9 billion. It should be noted that we are speaking about "expenditures", not "costs". Data on the latter is not presently available, to the best of our knowledge.

The concept proposed in S.1391 would not address any of the three preceding factors, and in our opinion, would not therefore be appropriate for application to nursing homes.

B. The second area of difference lies in the impact which the Medicaid program has on nursing homes as opposed to hospitals. At the present time, Medicaid pays for approximately 54% of the patients in nursing homes, while only 15% in hospitals. Because of the enormity of the portion of Medicaid patients in nursing homes, the payment systems utilized by the Medicaid program are extremely influential in terms of the total expenditures for nursing homes. The importance of this issue in regard to the non-comparability between the existing nursing home situation with that of hospitals, can not be over-emphasized.

Under the existing Medicaid payment system, nursing homes are not at this time being paid on the same basis as hospitals. The Medicaid program has been required to pay hospitals on the basis of the "reasonable cost of in-patient hospital services provided under the plan (State Medicaid Plan)". While at the same time, until the passage by Congress of P. L. 92-603, there was no similar specific Federal mandate as to the basis of payment to nursing homes. As a result, many States utilized payment methods which did not recognize and were unrelated to the "reasonable cost" of providing skilled or intermediate nursing services under the Medicaid program. While this situation would change once the States and the Federal government belatedly implement Section 249 of P. L. 92-603, and require that payments to nursing homes be made on a "reasonable cost related basis", the relationship between costs and the payment systems as they exist today, are not comparable with that of hospitals.

The key, however, is that until Section 249 is implemented, there is really not a valid statistical base on which to implement the concept for nursing homes, as proposed under S. 1391 for hospitals.

In summary, we would urge that the Subcommittee analyze the four concerns which were noted earlier regarding the proposed ceilings on hospital revenues, and would, for the reasons outlined, fundamentally oppose their application to nursing homes.

Next, in regard to the proposals to provide authority to the Secretary of Health, Education and Welfare to promulgate uniform functional accounting systems for each type of provider under Medicare and Medicaid, we would like to offer several observations.

First, we would strongly support the development of a uniform cost and statistical reporting system for all health care programs in which the Federal government is financially participating. As the Chairman and the Members of the Subcommittee are well aware, it is very difficult at the present time to develop data which can be utilized by the public, the government, and the providers in any meaningful way. The development of a uniform cost and statistical reporting system would assist in clarifying and providing the needed information to alleviate many of the problems which are plaguing our health care system today, not the least of which is the confusion which is caused by the duplication of governmental reporting forms, as well as their lack of uniformity.

From a provider's perspective, the present lack of such a uniform functional system is resulting in a massive paperwork burden on providers at a tremendous cost to the Federal government. You will find attached a sample list of the governmental agencies which a typical nursing home participating in various governmental programs might be reporting to and being surveyed by. Each at the present time usually has its own separate reporting forms which the provider must submit to the agencies. We have estimated that the current duplicative and disjointed reporting non-system is costing the nursing facilities annually approximately $50 million nationally. This process is happening while, as everyone is aware, we are still having reports about the fraudulent and abusive practices of providers and beneficiaries which negate many of the positive aspects of the Medicare and Medicaid programs.

We would therefore, support an amendment to S. 1391 which would establish such a system. We would hope that consideration would be given to including in the amendment language deeming such a system as being acceptable for meeting the requirements of all government health care agencies.

While a uniform reporting system will not solve all of the problems, we do feel that it will assist in eliminating the current confusion which plagues the programs. It would also be extremely valuable if not mandatory, in establishing the necessary data base required to obtain an objective reduction in the inflation of health care costs.

As for the establishment of a national "uniform functional accounting system", we would like to offer several observations in terms of nursing homes.

At the present time, several States, as a result of their implementation of Section 249 for their State Medicaid plan, are developing State uniform accounting systems which they intend to apply to all providers of skilled and intermediate care services participating in their State Medicaid program. California, for example, is very close to implementing just such a system. Because these systems vary from State to State, and they are in their initial stages, we would caution against immediately attempting to implement a national "uniform functional accounting system" which might supplant the work which has been done in these States. We would recommend that the Secretary be provided the time, and be requested to evaluate and review the impact which these systems are having under the Medicaid program.

It should be noted that the primary purpose of any accounting system is to meet the needs of the management of an organization. This objective, however, must be accomplished in a manner which assures that financial statements are easily understood externally by those third parties who have an interest in the organization's results of operations.

In our field, the third party with the largest interest is, of course, the government. Therefore, our accounting systems must be capable of producing financial reports which are easily understood by the responsible government authorities and meet their management needs in administering their health programs.

Yet, at the same time, the accounting system must be flexible enough to accomplish its primary purpose of meeting the facility's or parent organization's needs. This is the point which is bothersome to us in terms of the adoption of a requirement of a national uniform functional accounting system. We fear that a national uniform system would tend to be too rigid, and become entangled in time-consuming administrative red tape which could severely undermine the financial viability, and thereby the delivery capabilities, of the facilities.

It is for this reason that we feel time is needed to study the impact which the State uniform systems, mentioned earlier, will have in meeting both the needs of a facility's management and the government.

There is an additional factor to be considered regarding the government's programs, and that is the significant differences which continue to exist between the Medicare and Medicaid programs. These basically mandate that individual providers allocate their expenses on a basis which reflects their facility's particular characteristics, in terms of the programs which they participate in, and the extent of that participation.

The Medicaid program presents another problem, in that each State, in effect, has its own payment system, each with its own payment peculiarities. As noted previously, because of the size of the portion of Medicaid patients in nursing homes, this program is particularly important to the industry.

We, however, at the same time would point out that the Federal regulations implementing Section 249 of P. L. 92-603 would require that each State: develop and apply a uniform cost report; conduct audits in accordance with generally accepted audit standards; and that facilities maintain their accounting records on the basis of generally accepted accounting principles, utilizing the accrual method of accounting. Inherent in this set of requirements is the requirement that the accounting practices of providers be sufficient to generate the necessary data for statistical measures to evaluate the cost effectiveness of the allocation of costs among accounts.

To facilitate this, it may be necessary to more clearly define the accounting principles, standards, procedures, and methods of recording the financial activities of participating providers. This appropriately should be done in a non-discriminatory manner, which applies a set of standards to all providers of similar characteristics.

In light of my earlier comments, it should not be overlooked that there will be a significant cost to the States and the facilities in implementing the various uniform accounting and reporting systems. The cost to nursing facilities alone might run as high as $250 million, if implemented nationally. If these systems are mandated by the Federal government, their costs should be a fully reimbursable cost of the programs.

In summary, given the government's predominance in the purchase of nursing home services and the State by State variances in the major program through which such services are purchased, we would recommend that

1. The Department of Health, Education and Welfare be requested to evaluate the uniform accounting systems being adopted by the States under Section 249 of P. L. 92-603.

2. The Department of Health, Education and Welfare be requested to consult with interested parties, including representatives of the professional accounting standards boards/organizations, providers, and the public, regarding the establishment of a model functional accounting system for each type of provider under all programs in which the Federal government is a participant.

3. The model accounting system be designed not as a restrictive cost control, but rather as a flexible and functional method to meet the basic management needs of both a facility and those of the government programs.

4. The Department of Health, Education and Welfare be requested to develop a model functional accounting system, which in whole or in part, could be available for the voluntary use by the various authorities and providers of services under the programs within four years.

5. That the cost of implementing such a uniform functional accounting system by the providers by fully reimbursable by the Federal government.

Mr. Chairman, we appreciate this opportunity to offer our views regarding these issues for the Subcommittee's consideration.

TYPICAL INSPECTIONS OF NURSING HOMES

PARTICIPATING IN FEDERALLY SUPPORTED PROGRAMS

1. Accreditation survey by Joint Commission for the Accreditation of Hospitals if accredited or seeking accreditation.
2. Beauty shop inspection by State Board of Cosmetology if facility has beauty shop for its patients.
3. Blue Cross inspection if certified.
4. City sanitation inspection every six months.
5. Civil rights inspection usually in conjunction with licensure-Medicare-Medicaid inspection, but can be and sometimes is separate.
6. County Health Department inspection every 2 months.
7. Federal Housing Authority annual inspection if facility has FHA mortgage.
8. Federal life safety annual inspection.
9. Financial audit survey by Medicare.
10. Financial audit for Medicaid patients by State with audits averaging from 1 to 2 weeks.
11. Fire inspection by City fire chief 1 or 2 times a year.
12. Fire inspection annually by Division of State Fire Marshal.
13. Fire, liability, etc., insurance inspection by carrier.
14. Licensure-Medicare-Medicaid annual inspection by State.
15. Medical evaluation survey by State.
16. Narcotics inspection by Federal Bureau of Narcotics.
17. Nursing service inspection by State Board of Nursing.
18. Occupational Safety and Health Administration (OSHA) inspection.
19. Pharmaceutical inspection by State Board of Pharmacy.
20. Post-licensure-Medicare-Medicaid follow-up survey by State Department/Agency.
21. Pre-licensure consultation by State.
22. Review of the performance of surveyors by U.S. Department of Health, Education and Welfare, to determine whether State surveyors are doing their jobs properly.
23. Safety inspection by workmen's compensation insurance carrier.
24. Unannounced inspections, at any time by State, County Health Department, fire marshal or any other authorized agency.
25. Utilization review audit by Medicare intermediary.
26. Utilization review survey by State if facility has Medicaid patients but no Medicare patients.
27. Utilization review audit by federal of facility and State performances.
28. Veterans Administration annual inspection if VA certified.
29. Wage and Hour Administration inspection.
30. Workmen's compensation review by Department of Commerce.

STATEMENT OF
THE NATIONAL HEALTH LAW PROGRAM
TO
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
AND
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE
ON
THE HOSPITAL COST CONTAINMENT ACT OF 1977, H.R. 6575

May 17, 1977

Mr. Chairmen and Members of the Subcommittees:

The National Health Law Program (NHeLP) is a Legal Services Corporation-funded support center based in Los Angeles. For the past seven years, NHeLP has been providing technical and litigation assistance to local legal services attorneys whose low-income clients have encountered difficulty in obtaining needed health care services from hospitals and other health care providers. During this period we have seen first hand how many private nonprofit hospitals enjoying tax-exempt status have persistently refused to provide charity care to the poor, preferring instead to "refer" indigent patients to other facilities for care. We believe that this experience contains some valuable lessons that are pertinent to the President's proposal to contain hospital costs and we would like to share these with you.

What Hospital Cost Inflation Means to Low-income Consumers

For the 25 million or so persons eligible for Medicaid benefits, inflation in the hospital sector has meant cutbacks in eligibility and benefits in most state Medicaid programs over the past few years. As the recent hearings of the Subcommittee on Health and Long-Term Care of the House Select Committee on Aging on the Impact of Medicaid Cutbacks on the

Elderly made clear, these eligibility and benefits reductions mean hardship and suffering for all eligible persons. Large portions of state Medicaid budgets -- ranging from about 20% to 55% or more -- are chewed up by payments made for inpatient general hospital services and outpatient hospital services, placing enormous strains on state budgets that in turn have led to a wave of cutbacks. In addition, the large proportions of scarce Medicaid dollars that are being drained off into hospital services means that increasingly smaller proportions are left for badly needed primary care services such as Early and Periodic Screening, Diagnosis, and Treatment for children. And even though Medicaid reimbursement for inpatient hospital services in unreasonably generous, many hospitals have curtailed or terminated altogether their particiaption in the program, claiming that the reimbursement is not adequate to cover the costs they have incurred.

For the millions of low-income Medicaid beneficiaries whose cost-sharing (deductible and co-insurance) obligations are not covered by state Medicaid programs under the "buy-in" option, 42 U.S.C. §1395u(a)(3), inflation in the hospital sector has meant increased deductibles and co-insurance requirements. Currently, under Medicare Part A, the hospital service deductible is $124 per spell of illness, while the daily co-insurance rate is $31 per day for the 61st through the 90th day of hospitalization. In announcing these new cost-sharing obligations (up from $104 and $26, respectively, in 1976), the Acting Secretary of DHEW noted that "this increase is due in large measure to the continued inflation in health care costs," 41 Fed. Reg. 43220 (Sept. 30, 1976). These deductibles and co-insurance requirements are, of course, imposed regardless of income or ability to pay, so they bear most heavily on those least able to afford it -- the elderly poor. Under the relevant statutory provisions, these Medicare cost-sharing obligations will continue to rise if the average per diem rates for inpatient hospital services are allowed to maintain their inflationary upward spiral.

For the roughly 21 million persons with no public or private insurance coverage for hospitalization expense whatsoever, and for the millions more with inadequate private health insurance coverage, inflation in hospital charges means one of two things: inability to get hospital care altogether, or staggering bills for whatever services are received. Of course, as hospital cost inflation continues unabated, many with private health insurance coverage are finding that their policies are not keeping pace and are consequently leaving them with less and less protection against financial catastrophe.

If there are so many excess hospital beds, why are so many low-income consumers unable to get needed inpatient services from the private nonprofit hospitals? Because notwithstanding their excess capacity, and notwithstanding their obligations as "charitable" tax-exempt institutions, and notwithstanding the obligations which many of them have under the Hill-Burton Act to provide "a reasonable volume of uncompensated services to persons unable to pay," many private nonprofit hospitals persistently refuse to provide needed inpatient services to persons residing in their service area who lack public or private coverage. Instead, they typically "refer" indigent persons to a publicly-operated hospital for treatment. In the many communities that lack any public hospital, this "referral" is made to some unspecified source of care, such as the street.

This pernicious practice is commonly referred to as "dumping." In the experience of legal services clients as well as outside observers, this practice is widespread and has been for some time. See Roemer & Mera, "'Patient Dumping' and Other Voluntary Agency Contributions to Public Agency Problems," 11 Med. Care 30 (Jan.-Feb. 1973). Given their long experience with avoiding their statutory obligations to persons unable to pay or persons with "undesirable" health conditions, such as alcoholism, the private nonprofit hospitals

have refined dumping to a fine, albeit callous, art. They may refuse to take injured people brought by ambulance into the emergency room unless an adequate showing of ability to pay can be made. They may treat people briefly in the emergency room and then "refer" them elsewhere for needed inpatient care. They may condition admission for inpatient care on the payment, in advance, of a large cash deposit, leaving those who are unable to afford the preadmission deposit to seek needed care elsewhere. Or they may "progressively transfer" patients who have been admitted but whose public or private coverage has run out before their course of treatment has been completed. Of course, regardless of the form it takes, dumping is hazardous to people's health. It also places great strains on the underfinanced, understaffed public hospitals to which most indigent patients are "referred" and impairs their ability to deliver high quality care.

Not all private nonprofit hospitals dump every person who cannot demonstrate an ability to pay the anticipated charges. When they do provide services, however, they bill these people at ever-escalating charges which usually far exceed their ability to pay. In the experience of innumerable legal services clients, the hospitals institute a variety of collection techniques ranging from computerized dunning to telephone harrassment to litigation. Hospital bills are one of the principal causes of personal bankrupcies. And all too often, private nonprofit hospitals that have received large federal subsidies under the Hill-Burton Act never inform indigent persons of their potential eligibility for free or below-cost services under the terms of that Act. Similarly, private nonprofit hospitals that are exempt from federal or state income and/or sales taxation or local property taxation as "charitable" institutions almost never inform low-income people of their potential eligibility for charity care under the obligations deriving from their "charitable," tax-exempt status.

It is essential to understand the relationship between dumping and collection practices, on the one hand, and the drive toward capital expansion by nonprofit hospitals on the other. In the words of one of our favority hospital administrators,"dreams must be paid for." The dreams to which he refers, of course, are new hospital construction and a profusion of high technology equipment. These dreams are often paid for, in part, by the excess of patient revenues over operating expenses which, in a nonprofit institution, are labelled surplus, net income, or working capital, rather than profits. This excess of revenues over expenses is then frequently applied toward the financing of capital construction or equipment. Since charity allowances are treated as deductions from patient revenues, the greater the amount of charity care, the lower the excess of revenues over expenses available for capital expenditures. The experience of legal services programs and their clients has been that many of those private nonprofit hospitals which dump or pursue stringent collection measures do so in order to generate more working capital for expansion or purchase of new technology. That is one reason why there are lots of empty hospital beds and lots of poor people who are denied access to needed inpatient care. And of course, empty beds, like dreams, must be paid for, so charges must be raised, and bills become more onerous and dumping becomes more frequent.

Why H.R. 6575 is Vital to Low-Income Consumers

Even though some modifications are necessary, this bill contains several key principles which warrant full and prompt Congressional support. First, it recognizes that the problem of exploding health care costs can not be solved by shifting the costs from the federal budget to Medicare and Medicaid beneficiaries (through increased deductibles and co-insurance) or to state, county or local governments (through block grants). Instead, it goes to the heart of the problem: monopolistic pricing practices by institutional and individual providers.

While hospitals are not the only providers that are currently out of control, they are as good a place as any to start. And the savings to the Medicaid and Medicaid programs will hopefully forestall further cutbacks in those programs.

Second, the ceilings on permissible increases in hospital revenues may be too generous, but they do nonetheless extend to all payors, not just Medicare and Medicaid. It is absolutely essential that this principle be maintained, for if the reimbursement controls are limited only to Medicare and Medicaid, then private nonprofit hospitals will respond by further increasing what discrimination now occurs against public program beneficiaries and/or will shift the unreimbursed costs of servicing public program patients onto their private patients. In addition, the large urban public hospitals, which provide an enormous amount of care to Medicare and particularly Medicaid beneficiaries, will find themselves in even greater financial distress if their main sources of reimbursement reduce their payments.

Third, the bill proposes an annual national limit on capital expenditures. Altogether too much of this nation's scarce public and private capital has gone into inpatient hospital construction or more sophisticated technology. As Congress expressly found in the National Health Planning and Resources Development Act, section 2(a)(4), incentives are needed to stimulate more primary care and preventive health services, not more hospital capacity. This is particularly true in rural and urban medically underserved areas, where community groups who want to establish health clinics and ambulatory care centers often find that the start-up capital is simply not available. The only way to correct this gross maldistribution of resources is to place a national ceiling on allowable capital expenditures and then, within this ceiling, to redirect the flow of capital to where it is most needed -- the urban and rural areas lacking adequate primary care facilities.

Finally, this hospital cost containment program is, by its own terms, transitional to a program of permanent reforms in the delivery and financing of health care. This linkage is essential, for in the long run, a cost containment program can only be effective and equitable to all classes of consumers if major changes are made in the way in which health care is delivered and financed in this country. This reorganization must involve a strong shift in emphasis from institutional medicine that relies heavily on sophisticated technology to an emphasis on comprehensive, family-centered primary care. To get from here to there, however, the existing drain on scarce public and private resources by institutional providers must be stemmed. This bill represents an important step in that direction.

It must be noted that all health consumers in this country, and not only the poor, have a strong interest in these principles. Working class and middle class consumers will benefit from limits on hospital reimbursement, both as taxpayers and as purchasers of hospital insurance coverage. Since the program covers all payors, and not just Medicare and Medicaid, they will not have unreimbursed costs shifted onto them by the hospitals as private patients. In addition, it is working and middle-class consumers who pay large amounts toward the subsidization of excess hospital bed capacity, both in inflated routine service charges and in payment for unnecessary surgery, unnecessarily long stays, and unnecessary ancillary services. Finally, all health consumers will benefit from a universal national health plan that provides comprehensive coverage with universal financing, for which this transitional cost containment program is a necessary predicate.

Far Stronger Anti-Dumping Provisions Are Required

The basic scheme of Title I of the bill is to constrain increases in hospital revenues -- or, more specifically, reimbursement due or charges imposed for inpatient services. More-

over, these limits apply to each class of payor, whether cost-related, such as Medicaid, Medicare, and many Blue Cross plans, or charge-related, such as commercial indemnity insurers and self-pay patients. Thus, as noted before, the hospitals operating under these ceilings would not be able to cover their "losses" from one class of payor by increasing their charges to another. This feature, combined with ceilings tied to charges imposed, creates incentives for revenue-maximizing hospitals to dump.

Under generally accepted accounting principles as set forth in the AICPA Hospital Audit Guide (1972), charity and other allowances, as well as provision for uncollectible accounts (or bad debts), are treated as deductions from patient revenues. Thus, net patient revenues equals gross patient charges less: (1) charity and other allowances and (2) provision for uncollectible accounts. The proposed cost containment ceilings apply to gross, not net, patient revenues. Therefore, a hospital operating under the proposed ceiling that is interested in maximizing its actual revenues (what private nonprofit hospital is not?) will seek to maximize its net patient revenues by minimizing its deductions from gross billed charges. This means minimizing the amount of charity care allowances, if any, that the hospital is currently providing to the indigent, and minimizing the amount of uncollectible accounts that it carries.

Minimizing the amount of charity care is easy, since the hospital industry has had so much experience with dumping techniques. A hospital need merely stop providing whatever care it is giving to anyone who, upon financial examination, looks poor in relation to its charge structure for the needed services. Minimizing the amount of uncollectible accounts takes a bit more work, but the idea is the same. On the front end, the hospital must screen out those persons seeking inpatient admission who lack the requisite financial ability to pay; on

the other end, the hospital and/or its collection agents must squeeze as hard as possible on those persons who have already received treatment and have outstanding balances on their bills.

H.R. 6575 at least recognizes that the proposed ceiling on hospital reimbursement will cause private nonprofit hospitals to intensify their dumping of indigent patients. Proposed section 126 provides that hospitals on which low-income patients are being dumped by other hospitals may complain to the appropriate Health Systems Agency regarding "improper changes in admission practices." The HSA must investigate such complaints and refer its conclusions to the Secretary of DHEW, who has the discretion to bar an offending hospital from participating in Medicare or Medicaid.

As a recognition of the need for clear and effective statutory prohibitions against patient dumping, this provision is entirely appropriate. As a proposed remedy for patients who have been or will be dumped, however, this provision is a joke. If this proposed "maintenance of effort" provision is allowed to stand in its current form, the poor and working poor will have no protection whatsoever against the wholesale dumping that is certain to accompany the imposition of a ceiling on revenue increases as proposed in this legislation.

There are a number of reasons why section 126 will not prevent patient dumping. First, the only people who can complain about dumping are hospitals. In most communities, this will mean public hospitals which traditionally have served as the provider of last resort for those turned away by private nonprofit facilities. These hospitals are unlikely to complain about dumping because they will not know until well after the fact, if ever, that patient dumping has been increasing. And even if they do manage to compile patient census data which indicates that dumping has increased, they will rarely, if ever, be able to identify which hospitals have been "referring" which

patients to them. And if, by some chance, a public hospital manages to identify which patients have been dumped and by what other institution, the hospital administrator is unlikely to lodge a formal complaint against a fellow hospital administrator, particularly since there is no economic incentive for him to do so. Even if the dumping is eventually stopped, the public hospital will not, under the proposed legislation, be able to recoup from the offending hospital its costs of providing services to the dumped patients or the administrative costs of monitoring for dumping and tracking down the sources.

A second reason why section 126 won't work is that the enforcement mechanism, in the first instance, involves the Health Systems Agencies. Most of these agencies are already understaffed and underfunded relative to their existing statutory responsibilities under Title XV of the Public Health Service Act. In the absence of any funding for additional staff and training, few if any HSAs would be able to carry out their investigatory and enforcement functions under this section at all, much less in a timely and effective manner. Furthermore, even if the HSAs were somehow adequately staffed to meet this responsibility, there is a very serious question as to whether the provider-dominated HSA governing bodies in many communities would countenance,much less act upon, a staff finding of noncompliance with the anti-dumping requirements by local provider institution.

Another reason that section 126 won't work is the enforcement role given to DHEW, which is authorized -- but not required -- to impose sanctions against hospitals somehow found to be in violation by an HSA. Given its sorry performance at implementing the related Hill-Burton program, it is inconceivable to us that DHEW would ever take any action against any facility found to be in violation of a prohibition against dumping.

The Hill-Burton program, of course, has since 1947 required hospitals which have received federal construction and modernization subsidies to serve the community, not to dump. More specifically, these 3000 or so hospitals gave contractual assurances in accepting the federal subsidies that they would make their facilities and services available to the entire community, 42 U.S.C. §291c(e)(1), 42 C.F.R. §53.113, and that they would make available to the subclass of the community that is unable to pay some or all of the full charge for needed services "a reasonable volume of uncompensated services," 42 U.S.C. §291c(e)(2), 42 C.F.R. §53.111. Notwithstanding widespread violations of these statutory and contractual obligations by Hill-Burton grantees, the responsible state agencies took almost no enforcement action. Accordingly, Congress in 1974 revised the Hill-Burton Act so as to shift the responsibility for monitoring and enforcing compliance from the states to DHEW, Title XVI of the Public Health Service Act. Specifically, section 1602(6) of the Public Health Service Act, 42 U.S.C. §300o-1(6), expressly requires the Secretary to promulgate regulations prescribing the manner in which Hill-Burton grantees must comply with their "community service" and "uncompensated services" assurance. That section also requires the Hill-Burton facilities to submit periodically to the Secretary data and information concerning their compliance with these obligations.

These provisions were enacted into law on January 4, 1975. As of May 17, 1977, some 2 1/2 years later, DHEW has not issued any such regulations or even required facilities to submit data concerning the extent of their service to the community, including persons unable to pay. During this period, numerous complaints concerning patient dumping and other "community service" and "uncompensated services" violations by federally-assisted hospitals have been filed with the Department by low-income consumers, legal services attorneys, and others, all to no avail.

In our view, the principal reason these clear statutory mandates have been ignored by DHEW in the face of clear evidence of the need for prompt enforcement action is that the Department has no interest whatsoever in assuring that Hill-Burton hospitals serve the entire community, as promised. Unlike Title XVI of the Public Health Service Act, proposed section 126 is precatory, not mandatory; DHEW need not take any enforcement action even if it were so inclined. And the evidence is overwhelming that the Department is not now, and is never likely to be, so inclined.

Yet another reason that section 126 won't work as proposed is the lack of baseline data on hospital admission practices against which hospital performance under the cost containment program could be assessed for evidence of dumping. Although the hospital industry for some time now has been moaning and groaning about an excess of government-required paperwork, DHEW, to the best of our knowledge, has no information at all on hospital admissions practices vis-a-vis persons unable to pay. As noted above, DHEW has never bothered to administer an assurance reporting form to Hill-Burton facilities, which constitute a large segment of the hospital industry. Similarly, DHEW has ignored the express requirement of section 1533(d) of the Public Health Service Act, 42 U.S.C. §300n-2(d), to develop uniform reporting and accounting systems which, among other things, would yield information about charity and non-charity admissions. The Medicare cost report, which all hospitals participating in Medicare must file, does not contain any information relevant to patient dumping other than the gross dollar amount of "allowances and discounts on patients' accounts" for purposes of the revenue and expense statement, worksheet G-3. This item is of no use in assessing admissions practices, however, because it fails to differentiate between charity care provided to indigents and bad debts written off and does not contain a breakdown of the number of patients in each category. Furthermore, DHEW recently announced the withdrawal of its uniform

hospital discharge abstract, which might have been a source for information about patient treatment and "referral" patterns. 42 Fed. Reg. 18904 (April 11, 1977). In short, there is no baseline data on admissions practices, and DHEW has not demonstrated any interest in obtaining such information.

Finally, section 126 won't work because the sanction -- termination of participation in Title V, Medicare, and Medicaid -- is totally unrealistic. As a general rule, regulatory sanctions must bear some reasonable relationship to the offense in order to be effective. Given the dependence of many hospitals on Medicare and Medicaid funding, application of this sanction would undoubtedly put many violators in serious financial difficulty. Both DHEW and the hospitals know that a sanction with such a result will not, as a practical matter, be applied except in extraordinarily egregious cases. Thus, for practical purposes, there is no sanction whatsoever, and hospitals will be able to dump with impunity. It must also be emphasized that termination of Medicare and Medicaid assistance penalizes those persons eligible for coverage under those programs by denying them access to the services at the offending facility; we can see no logic in a sanction which denies access to public program beneficiaries in the name of assuring access for the poor.

A Proposal to Minimize Patient Dumping

An effective hospital cost containment scheme is essential to the financial integrity of existing and future public programs, but the savings must not come at the expense of the poor. A ceiling on charge increases by payor will encourage revenue-maximizing hospitals to dump their indigent patients in order to minimize deductions from revenues. To forestall this dumping as much as possible, H.R. 6575 should be amended to rely not on some distant federal bureaucracy, but on those most directly affected by the dumping -- low-income consumers -- to enforce the anti-dumping prohibitions. An effective private enforcement mechanism would have to include the following elements:

1.) A uniform accounting and reporting system. This must include information on patient admissions and "referrals" and must distinguish between charity care and bad debts. Unless all hospitals operating under the ceilings are required to adopt uniform accounting and reporting conventions, there is no way to relate their performance from one year to the next or to compare their performance with that of other facilities.

2.) An absolute standard for the provision of free or below-cost care to persons unable to pay. One such standard might be that initially proposed by DHEW in regulations implementing the Hill-Burton program in early 1972: the higher of 5% of the cost of operations or 25% of net income. 37 Fed. Reg. 7632, 7633 (April 18, 1972). (These "presumptive compliance" standards were subsequently watered down as the result of intervention by the industry-dominated Federal Hospital Council). Another standard might require a constant charity case mix of not less than 10% of total inpatient admissions, combined with a constant patient mix and a constant gross to net revenue ratio, or recovery rate on billed charges.

The precise nature of the standard is less important than the need for some minimal standard of charity effort. In the absence of any baseline data indicating what amount of charity care -- as distinguished from general bad debts -- a hospital has provided during the base year, it will not be possible to evaluate the hospital's subsequent performance. A firm benchmark is necessary. Since most of the patients who are dumped will be dumped because of their medical indigency, a minimal charity care effort must be required of each hospital. The standards proposed above articulate, in numerical terms, the duty of hospitals operating under this cost containment program not to dump.

3.) A standard definition of charity cases. An absolute standard against which to measure hospital admissions and discharge practices must include a uniform definition of indigency; otherwise, hospitals will adopt different eligibility

standards for charity care. The result -- inconsistent admissions policies from facility to facility within the same community - would be unfair both to low-income consumers and to the hospitals themselves, since the community service/ charity care "burden" would not be equitably distributed. Moreover, without a uniform definition of indigency, there is no way in which charity care -- i.e., care given to persons unable to afford it -- can be distinguished from bad debts -- i.e., uncollectible accounts of patients to whom care was not given due to indigency. The formula contemplated by proposed section 126 of the bill -- a reduction in the proportion of inpatients for whom reimbursement at less than charges is anticipated -- fails to make this charity care/bad debts distinction. Consequently, the poor, who are almost always the victims of dumping, would not be protected, since hospitals could maintain the required proportion by simply increasing their courtesy or contractual allowances, or by adjusting their provision for uncollectible accounts upward to offset any declines in the amount of charity care rendered to poor people.

There is precedent in a hospital cost containment program for charity care guidelines. At the urging of the Baltimore Legal Aid Bureau, Maryland's Health Services Cost Review Commission has recently adopted a set of eligibility standards for charity care which it is administering on a demonstration basis to several hospitals in Baltimore. These guidelines combine a uniform standard for indigency with a requirement that the eligibility determinations be made prior to admission, except in emergency circumstances. These guidelines also recognize that persons with Medicaid coverage are not charity patients, and that only those persons with very limited third party coverage or no coverage at all could qualify as charity cases. It should also be noted that prior determination of eligibility, central to any rational charity care policy, is also required

of Hill-Burton hospitals under the "uncompensated services" regulations, 42 C.F.R. §53.111(f).

4.) Effective public notice of a hospital's obligation not to dump. Unless people know that hospitals operating under this cost containment program may not dump them for inability to pay in order to maximize their revenues, they cannot be expected to seek redress for such illegal behavior. And if the people being dumped (or their representatives) do not attempt to stop a hospital's illegal dumping, then no one is likely to do so. The way in which low-income communities are most likely to find out about a hospital's obligation to serve its members is through the facility itself, as well as through the local Health Systems Agency. Thus, all hospitals covered by this program should be required to give clear, understandable notices to all of their patients -- outpatients as well as inpatients -- of their obligation not to dump. In addition, hospitals should be required to post legible notice of the availability of charity care in appropriate locations such as the emergency room, admissions office, and business office, much as Hill-Burton-assisted facilities are now required to do. 42 C.F.R. §53.111(i). In addition, the HSAs should be required to make information about hospitals' obligations under this cost containment program, including the duty not to dump, available to the communities they serve through, for example, advertisements on buses and subways.

5.) A complaint process which can be invoked by any person or organization. Recourse to the complaint procedures should not be limited to hospitals, as section 126 proposes, but should be extended to include any person, including low-income consumers who have been adversely affected by dumping practices.

6.) A complaint process that provides timely administrative relief to injured parties without foreclosing access to judicial remedies. As under existing section 126, complaints should be filed with the appropriate Health Systems Agencies,

which should be allotted adequate funds for hiring and training investigatory staff. In those communities where the HSAs consider this work high prioirty, they should be allowed to identify and sanction violators. However, where the HSAs do not consider this responsibility important, low-income consumers who are being dumped by hospitals should have direct and timely access to the federal courts to enforce a right to fair treatment by a hospital conferred on them by this statute. More specifically, HSAs should have 30 days to process and resolve a complaint against a hospital, except in an emergency situation. Upon the expiration of 30 days, or in any emergency (i.e., a person in serious condition has been refused treatment for inability to pay and has no other source of necessary care), any person should be entitled to bring an action for injunctive relief and damages, plus attorneys' fees, against the offending facility in federal district court. As argued above, it is useless to involve DHEW in this complaint process: the Department has neither the interest nor capacity to respond effectively to individual citizen complaints about dumping. In this connection, HSAs should be statutorily authorized to handle such complaints without waiting for DHEW regulations.

7.) Sanctions that deter dumping and are reasonably related to the offense. Since the motivation for dumping is often financial, it makes sense to establish financial sanctions. The problem with section 126 is that the financial sanction -- termination of Medicare and Medicaid participation -- will often be catastropic, and is therefore unrealistic. Instead, the sanction should be closely related to the charity care standard suggested above. For example, if the minimum level of charity care required were 25% of net income, then a hospital found to be in violation of this requirement by an HSA or a federal court should be required to isolate that entire amount

in a special charity care fund, administered by a court-appointed master. Persons who had been dumped, as well as other hospitals from which those persons had eventually received care, could then file claims for compensation against this fund. (Of course, this fund would be independent of hospital's obligation for the fiscal year following that in which the violations occurred). In addition, authorization of individual damage actions, as urged above, would further deter hospitals from dumping by creating uncertainty as to their financial exposure in the event of a judicial finding of illegality. Finally, given the close relationship between restrictive hospital admissions policies and hospital capital expansion efforts -- i.e., revenues used for capital expansion might otherwise be used for care to indigents -- and given the importance of limiting unnecessary capital expenditures, the legislation should also provide that no hospital may receive a certificate of need for any proposed capital project unless it affirmatively demonstrates that it is in full compliance with its duty to serve the entire community, including those unable to pay.

Conclusion

We appreciate the opportunity to make this statement for the record. If the Chairmen or any members of the Sub-committees would like an elaboration of any of the proposals set forth herein, please do not hesitate to contact Mr. Andy Schneider, our staff attorney responsible for legislative affairs.

NATIONAL TAXPAYERS UNION

325 PENNSYLVANIA AVENUE, SOUTHEAST WASHINGTON, DISTRICT OF COLUMBIA 20003 TELEPHONE (202) 546-2040, 546-2085

STATEMENT
on
S. 1391
submitted to the
HEALTH AND SCIENTIFIC RESEARCH SUBCOMMITTEE
for the
NATIONAL TAXPAYERS UNION
by
Sally Cromwell
June 24, 1977

On behalf of the National Taxpayers Union, I thank the Subcommittee for this opportunity to present our views on S. 1391.

There can be no doubt that America's health care system is facing a crisis of serious magnitude. As all the stastical indicators reflect, costs have skyrocketed over this past decade. Clearly governmental action will be necessary to restore price stability to the health industry, but just as clearly, that action must be carefully considered, because an ill-conceived solution will not solve the problem, but compound the crisis. The National Taxpayers Union believes the evidence demonstrates that our present crisis is largely the result of past governmental legislation and regulation.

A study of hospital regualtion in New York showed that hospitals must answer to no less than 164 federal, state, county, and city agencies. Needless to say, this kind of regulation is both confusing and costly for the hospitals involved. The resulting increase in paperwork and hence personnel costs are a significant cause of rising prices.

Similarly, minimum wage legislation affects hospital costs disproportionately to those of other industries in that wages comprise about 60% of most hospital budgets. The increase in hospital wages in 1975 accounted for 28.5%

of the increase of the cost to the patient.

The problem of the cost of over-bedding can also be directly linked to government interference. In 1974, the Hill-Burton program was responsible for adding 40% of all new beds in non-federal hospitals, and the present budget provides for 505 million dollars to be spent for health planning and construction. Since about 30% of all hospital beds are presently vacant and the cost of maintaining an empty bed is 2/3 of the cost of maintaining a full one, government planning and intervention has again helped to drive up hospital costs.

Federal health care programs contribute to rising hospital costs. For example, when Medicaid and Medicare pick up the tab, expensive medical services seem to be free. This encourages excessive utilization, driving up the costs of hospital care. There is also little incentive for the Medicare recipient to be cost conscious, resulting in increased usage of the most expensive services.

The soaring cost of malpractice insurance provides another explanation for the explosion in hospital costs. The American Hospital Association estimates that hospitals are now spending more than one billion dollars a year for liability coverage, as opposed to 100 million dollars as recently as 1972.

We need not merely speculate about the effects of hospital cost containment; the experience of the United Kingdom in trying to hold down the cost of health care provides insight into what the United States would experience were it to follow suit. Although the British have been successful in containing costs, the result has been a significant reduction in the quality of services.

The rising costs which have been outlined here are beyond the control of the hospitals themselves. In view of this, a limit on hospital income can only result in a decline in quality medical care. Rather than the imposition of an artificial limit on hospital costs which can only cause a reduction in the quality of care, we urge the committee to consider deregulation of the medical industry as an alternative to price control.

nebraska methodist hospital · 8303 dodge street · omaha, nebraska 68114 · (402) 397-3000

May 27, 1977

The Honorable Edward M. Kennedy
Chairman, Subcommittee on Health
Committee on Human Resources
United States Senate
431 Russell Senate Office Building
Washington, D. C. 20510

Dear Senator Kennedy:

The attached testimony concerning the Hospital Cost Containment Act of 1977 offers my comments on the legislation and recommendations for dealing with the complex problem the legislation is intended to resolve. I would appreciate it if this statement would be entered into the record of testimony your committee has received concerning the Hospital Cost Containment Act (S. 1391).

Sincerely yours,

J. W. Estabrook, F.A.C.H.A.
Administrator

JWE:sb

Enclosure

95 195 1869

TESTIMONY OF NEBRASKA METHODIST HOSPITAL ON THE HOSPITAL COST CONTAINMENT ACT OF 1977 (H.R. 6575 AND S. 1391) SUBMITTED TO THE HEALTH SUBCOMMITTEES OF THE COMMITTEES ON FINANCE AND HUMAN RESOURCES OF THE UNITED STATES SENATE, MAY 27, 1977.

I appreciate having this opportunity to comment on the Hospital Cost Containment Act of 1977, H.R. 6575 and its companion bill in the Senate S. 1391. My comments will be limited to three areas: The deficiencies that exist in the bill; the impact of the bill upon Nebraska Methodist Hospital and the five hospitals which are managed through a non-profit division of the hospital and my recommendations for dealing with the increase in the cost of hospital care.

The primary deficiency in the bill is that an arbitrary cap is provided without considering the tremendous differences which exist between hospitals. Shared Service Systems, a non-profit division of Nebraska Methodist Hospital, currently manages five hospitals in Nebraska, Iowa and Missouri. These institutions include a 70-bed hospital in Fairfax, MO., an 85-bed county-owned hospital in Harlan, IA., 30-bed hospitals in Tilden and Plainview, NE., and the 100-bed Childrens Memorial Hospital in Omaha, NE. Each of these institutions has a different mix of services with different skill levels required among employees. Each institution has a different physical plant with varying needs for capital improvements. It is unrealistic to assume that a nine percent cap will work as well for each of these institutions as it does for 379-bed Nebraska Methodist Hospital, which provides such services as open-heart surgery and cancer therapy which require the use of intricate and expensive equipment.

The second major problem with the Hospital Cost Containment Act of 1977 is the fact that an arbitrary cap penalizes efficiently operated institutions. For example, Secretary Califano has stated that hospitals can provide significant savings through better use of energy. At Nebraska Methodist Hospital, we have installed equipment to use heat from exhaust air to warm incoming air in the winter. Lighting has been reduced. We are currently studying a computerized system to totally monitor the energy used in the hospital in the hopes of obtaining further savings. Because of these steps which have already been undertaken, it is going to be difficult to realize further significant savings in the energy area. Furthermore, by the end of 1977, we will no longer be able to use natural gas, but must switch entirely to oil. Because oil costs about four times what we pay for natural gas, we are going to experience a sharp rise in our energy

costs during 1978.

Secretary Califano also suggests that significant savings can occur if hospitals use their present facilities more efficiently. Nebraska Methodist Hospital has averaged over 90 percent occupancy since 1970. On many days, we have a patient waiting list for elective procedures. Outpatient surgery and utilization review programs have been implemented to curtail hospital inpatient useage. Nebraska Methodist Hospital has achieved the lowest average adult length of stay (6.8 days) in metropolitan Omaha. Again, because of prior installation of efficiency programs, our present costs per patient day are at a minimum level. Hospitals that are operated less efficiently might consider similar programs, although some capital investments may be required. Cost increases, from external, uncontrollable sources, will force the reduction of patient services if our institution is to stay within a nine percent cap.

The bill does not provide consideration for increased reimbursement for changes in patient mix. Hospitals will see an increase in intensity of services with the development of outpatient and home health care programs. These programs will hospitalize a more acutely ill group of patients who will necessarily have higher costs associated with their care.

Title II of the Act will ultimately have the most detrimental impact to the quality of health care. It is estimated that the nation's hospitals are required to spend about $2.1 billion annually to replace obsolete equipment. A national ceiling of $2.5 billion annually will not allow for purchase of new equipment which will improve health care, increase employee productivity, shorten our patients' length of stay and reduce the cost of patients' hospitalization.

Another point which must be considered is that much of the National Health Planning and Resources Development Act (P.L. 93-641) has not been implemented. The health care field is beginning to function within the requirements of this law, although the cost benefits have yet to be recorded or realized. The imposition of the temporary controls,

as outlined in the Hospital Cost Containment Act of 1977, and permanent controls within two years, will disrupt the hospital industry and curtail health care progress.

In studying the impact of the proposed legislation on Nebraska Methodist Hospital, I see several areas that make the bill unworkable.

Because our fiscal year does not coincide with the October 1 fiscal year established in the bill, it is going to be impossible for the hospital to budget for a full year and know with any certainty what increase will be allowed for the final quarter of our fiscal year. This makes intelligent planning and budgeting impossible.

Another difficulty in the bill, is that it does not consider the broad range of costs over which a hospital administrator or board of trustees has no control. For example, prudent management of any institution dictates that insurance be purchased for major risks. In the area of medical malpractice insurance, however, we have seen enormous increases in recent years. For example, in 1974, Nebraska Methodist Hospital paid $63,000 for $10 million of coverage. In 1977, the hospital had to pay $485,000 for only $5 million of coverage.

Nebraska Methodist Hospital, and more than 80 hospitals and nursing homes in Nebraska, Iowa, Kansas and Missouri purchase many of the goods needed daily in a hospital or nursing home from Shared Service Systems. Even with the $6 million purchasing power of Shared Service Systems, for medical, surgical and food supplies, Nebraska Methodist Hospital has seen costs for many items rise significantly. For example: Coffee has risen from $34.19 per case in Dec. 1975 to $69.55 per case in March 1977. Intravenous solution has risen from $4.24 per case to $5.33 per case during the same period. Fluorescent bulbs have risen from $18.62 to $20.14 per case in that 15 month period.

Federal regulation has also added to the costs over which hospitals have no control. The Employee Retirement Income Security Act is one example. At Nebraska Methodist Hospital, we have been required to increase our contribution by $240,000 from $120,000 to $360,000 in a recent one-year period. The only thing that was changed in the pension program was the method of vesting--to bring the plan into compliance

with the new law--and the cost.

The Congress is currently studying proposals to boost the minimum wage from $2.30 per hour to $2.50 or $3 per hour. This proposal, along with the portion of the Hospital Cost Containment Act that provides for exemption of non-supervisory wage increases, will tend to compress the wage scale within the hospital, and make the important first line supervisor jobs much less attractive. If the minimum wage is raised to $2.50 per hour, and if some reasonable adjustments are made in wages for people with greater responsibilities, we could see as much as a nine percent increase in wage and salary expense, which comprises about 60 percent of our budget.

The capital expenditure limits are unrealistic because they do not consider area need, but divide the available dollars on a per capita basis. In Nebraska, it is estimated that our capital expenditures ceiling would be in the area of $10 million. We have seen, in Omaha alone, one project which replaced an inefficient hospital constructed in the 1800's, and reduced the number of beds in the community, absorb more than $70 million. Would this mean that one major construction project could absorb all capital expenditures available within a state, thereby requiring the use of obsolete equipment, or facilities, or the discontinuance of a service until a non-working machine or unsafe facility can be replaced?

From this review of the bill, I hope that it is apparent that it is unrealistic, unworkable, and, in fact, a form of wage and price controls on one segment of one industry. I urge your rejection of this bill.

Nebraska Methodist Hospital <u>is</u> concerned about the cost of health care. We have taken a number of innovative steps to contain those costs, and we are willing to work in a constructive fashion with the Congress or with local or national associations in an attempt to provide an equitable solution to the problem.

To be equitable, however, there are certain things that any legislation passed by the Congress must consider. These include the difference that exist between hospitals, for all hospital beds are not the same. Different costs are associated with care in rural and metropolitan hospitals, primary, secondary or tertiary care hospitals,

teaching hospitals and pediatric hospitals. Costs vary between private and public hospitals.

Differences in costs between hospitals for such items as capital, energy, medical malpractice insurance, educational programs, wage scales and other widely variable costs should be reimbursed under the present system.

A good program for cost containment should require only one financial audit which would serve all purposes. The same thinking should be applied to overlapping inspections and surveys by government at the federal, state, and local levels as well as non-governmental surveys. This would save a great deal of staff time and money for hospitals. In recent years, the flood of inspectors and auditors at our hospital has included our own independent auditors, auditors for our Medicare intermediary, the General Accounting Office from Baltimore and Kansas City, Internal Revenue Service, Department of Labor, Department of Health Education and Welfare, Joint Commission on Accreditation of Hospitals, state and city Departments of Health, Nebraska and Iowa State Department of Revenue, state and city fire marshalls and the Occupational Safety and Health Administration.

I also recommend that all payors, including the federal government, pay billed charges, not costs. An independent review agency, similar to the Interstate Commerce Commission or the Federal Power Commission would approve hospital charges. The independent review agency would be composed of individuals who have an in-depth understanding of the health care delivery system and freedom from potential conflicts of interest. This program could eventually eliminate the need for federal and state intermediaries which are now associated with Titles V, XVIII and XIX of the Social Security Act.

The federal government should develop an alternative reimbursement formula which will allow hospitals with low occupancy to provide long-term care without applying proportional allocation of overhead costs to all patients in such facilities. (If all third party payors paid billed charges, this proposal would be unnecessary.)

Hospitals should be encouraged to provide shared services. Currently, revenue from shared services provided to hospitals larger than 100 beds, or revenue from shared laundry services, is considered unrelated business income. This discourages sharing of services which provides significant savings for health care facilities.

It seems apparent that a number of equitable methods exist for providing some containment of the rising cost of hospital care. It is my firm belief that a thorough discussion of the issues and a fair minded approach will result in containment of health costs which benefit the consumer of health care in the short run, and protect and enhance the finest health care system ever to exist, so that it will be good for the next generation of American health care consumers. Nebraska Methodist Hospital stands ready to assist, in whatever way possible, to insure that quality health care will be available at a reasonable price for all Americans.

New Mexico Hospital Association

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Albuquerque, New Mexico 87106

Phone 505 265-3686

James L. LaCombe, F.A.C.H.A.
Executive Director

June 17, 1977

Dr. Stuart Shapiro
% Senate Finance Committee's
Subcommittee on Health
4228 Dirksen Senate Office Bldg.
Washington, D.C. 20510

SUBJECT: Opposition to S 1391 (Kennedy)

Dear Dr. Shapiro:

We would appreciate inclusion in the record of the Senate Subcommittee on Health the New Mexico Hospital Association's opposition statement (Tab A) to S 1391 (Kennedy), the Hospital Cost Containment Act of 1977.

One of our larger hospitals reports that if this bill was effective in their 1977 fiscal year, that they would have a revenue penalty of $3-million which would be disastrous to this hospital.

In addition to the problems we pointed out in Tab A, we would like to call the subcommittee's attention to the following with which we agree:

1) Extract of statement of Senator Herman Talmadge from the May 5, 1977, Congressional Register regarding the Hospital Cost Containment Act, S 1391 (Tab B).

2) Excerpt from statement of the Council on Wage and Price Stability, December, 1976 (Tab C).

Sincerely,

James L. LaCombe
Executive Director

JLL:tt

encl: Tabs A, B, & C

cc w encl: NMHA Board of Directors
AHA Wash & Chicago
NM Congressional delegation

PROBLEMS WITH THE HOSPITAL COST CONTAINMENT ACT OF 1977, S 1391 (Kennedy)
(approved by the NMHA Membership at its May 12, 1977, meeting)

The New Mexico Hospital Association opposes the Cost Containment Act of 1977 for the following reasons:

1. The formula on increase in revenues will eliminate technological innovation. Although the formula was designed to allow for changes in services and intensity, the GNP Deflator understates the effect of inflation on hospitals since hospitals intensively use rapidly increasing cost items such as utilities, plastic products, foods, postage, etc.

2. With limited resources, hospitals must make policy decisions on allocation of resources and who obtains what care. These policy decisions are better made as a part of a national health policy. The federal government appears unwilling to make these difficult decisions and is forcing these decisions upon the Board of Trustees, medical staffs and administration of hospitals.

3. The allocation of capital expenditures, strictly by population, may discriminate against New Mexico, with its small, rural, and widely dispersed, but rapidly growing, population. The plan does not recognize the greater needs of rural citizens for health care. Approximately $12-million would be available for New Mexico, which would not pay for the full costs of updating current facilities, let alone provide additional services necessary. Such limitations also would impede or cancel planned consolidation of services or other innovations which could lead to short and long-run cost containment. Thus, such an allocation, in effect, is contrary to the stated intent of this legislation of avoiding duplicative hospital facilities.

4. Individuals, regardless of their source of income, will not be allowed to obtain health care above certain minimal levels. Citizens are allowed to obtain private education regardless of cost, but this proposal would eliminate this alternative in health care. Due to the limitations on income, which discourage increased admissions, a hospital will have several alternatives, all of which are bad. Among these alternatives would be to discontinue admissions after the revenue limit has been reached and/or limit admissions during the year. This could lead to inappropriate shifting of patients to other facilities which may not be appropriately equipped to care for the patients' needs.

5. No incentives are included within this proposal. Only disincentives and punitive actions are included.

6. It does not reward hospitals which have kept their costs down. A hospital with high charges is allowed a larger increase than the hospital that has kept its prices low.

EXTRACT OF STATEMENT OF U.S. SENATOR HERMAN TALMADGE (D-GA) ON THE CARTER ADMINISTRATION'S BILL AS TAKEN FROM THE CONGRESSIONAL REGISTER DATED MAY 5, 1977

"I am less certain at this point as to my final decision with respect to an interim cap on hospital revenues.

"I understand the urgency of the problem and have in fact modified my proposal so that the long-term solution could begin operating earlier--the start of FY79.

"What we are left to deal with then is a 1-year period.

"My uncertainty over the wisdom of a cap on hospital revenues stems from a series of concerns:

"First, that a cap may become a floor;

"Second, that with all the exceptions, the cap may be ineffective as a ceiling;

"Third, that a cap by its very nature is arbitrary and tends to penalize those who have been efficient in the past and reward those who have been inefficient; and

"Fourth, that switching from our current control mechanisms on reimbursement to the new concept of a cap for 1 or 2 years, and then to yet another control concept as embodied in my bill, may cause such chaos within the hospital field as to cancel out the dubious savings involved.

"In short, I have not reached a final conclusion on the merits of the administration proposal for an interim cap on hospital revenues."

Excerpt taken from the Statement -- "The Complex Puzzle of Rising Health Care Costs: Can the Private Sector Fit It Together?" -- from the Executive Office of The President, Council on Wage and Price Stability, December 1976

In the Foreword (page iv) to the members and Adviser Members of the Council on Wage and Price Stability, William Lilley III, acting director, said in part:

"It is all too apparent that right now, with current reimbursement programs and the ubiquitous and often conflicting morass of regulations, that the federal government, instead of being part of the solution, is part of the problem of rising health care costs. This sorry state of affairs has come about despite the best of intentions of the government. To add yet another layer of cost-raising regulations, which would inevitably accompany any federal effort, would only be to compound the existing problem."

NEMA

RADIATION IMAGING PRODUCTS DIVISION

National Electrical Manufacturers Association
2101 L Street, N.W.
Washington, D.C. 20037 • (202) 457-8400

June 13, 1977

Senate Committee on Human Resources
Subcommittee on Health and Scientific
Research
United States Senate
Washington, D. C. 20510

Mr. Chairman and Members of the Committee:

This statement is being submitted for inclusion in the official record of the public hearings on S.1391 - Hospital Cost Containment Act of 1977 - conducted by the Senate Subcommittee on Health and Scientific Research.

It is submitted on behalf of the Radiation Imaging Products Division of the National Electrical Manufacturers Association (NEMA). This trade association group is composed of approximately 85 percent of all manufacturers providing high technology equipment to the health care field in the product areas of conventional medical and dental X-ray imaging, computed tomography, diagnostic ultrasound and nuclear medicine.

The radiological diagnostic equipment industry supports the intent and objectives of comprehensive health planning policy, specifically P.L. 93-641. The Health Planning and Resources Development Act of 1974 can be effective in the goal to meet community needs for organizing, delivering and equitably distributing health care services and facilitating the evaluation of implications of new medical technology.

However, we do not believe that S.1391 will be useful legislation toward reaching those goals. We believe there are two major inconsistencies with S.1391. First, Title I and Title II do not treat outpatient services equivalently. Title I excludes these services from control while Title II includes under the limit those capital expenditures necessary to implement an increase in outpatient services. Second, we believe that the capital expenditure rationing of available medical technology under Title II is not consistent with the objective of reducing the cost of health care.

It is our view that a ceiling on capital expenditures could adversely impact the future quality of health care. It would reduce the incentive of industry to continue to invest in beneficial research and development and certainly constrain a further desirable shift from inpatient to outpatient care.

Capital expenditures for medical technology equipment have resulted in the past in significant improvement in the quality of care for the patient while providing hospital cost savings. For example, technological advances in clinical laboratory equipment have enabled the laboratory technician to perform a more sophisticated series of tests in shorter time with greater quality control, resulting in improved patient management.

Today technical innovations in such equipment as ultrasound, nuclear medicine and computed tomography and other medical technology not only aid the physician in making life or death decisions, but contribute towards an important shift in patient care philosophy by providing effective and safe diagnostic technology on an outpatient basis, thus reducing the cost of medical care by lowering inpatient admissions. Before the availability of such technology, the physician had little choice when confronted with potentially serious patient symptoms of unknown origin but to admit the patient for a few days of specific observation with the possible use of some operative procedures or use of more expensive and hazardous diagnostic studies.

Today, in many cases with the aid of technology, the physician is able to make a quantitative assessment with little patient discomfort and without hospital admission. An example is in computed tomography. Studies[1] have predicted that by 1980, the number of potential procedures to be performed with this technology will be in the 6 to 12 million range. Three to six million or approximately 50 percent of these procedures will be performed on an outpatient basis. Of these 3 to 6 million procedures, some 33 percent or up to two million patients would have to be hospitalized if not for the non-invasive diagnostic capability of computed tomography. The result of this shift towards outpatient care indicates a savings of $500.00 to $1,000.00 per patient or an estimated national savings of $1.0 to $2.0 billion annually.

Technology-oriented industry invests relatively large sums of money in research and development. The effect of a ceiling on capital expenditures creates a regulated and possibly unstable market which could remove incentives for continuing private investment in future research and development, thereby reducing future necessary patient care

National Electrical Manufacturers Association

innovation. It is also reasonable to assume that the present level of privately funded medical R&D technology programs may have to be maintained by future government funding.

The annual cost of capital intensive technology for radiological diagnostic equipment in 1976 was approximately one-half of one percent of the cost of health care in the United States. We believe that the benefits of more accurate and safer diagnosis, shifts to outpatient care and reduced morbidity will make important contributions to the economic concerns of national health care costs.

It is our sincere hope that any viable program to contain rising health care costs will carefully consider the resources and historical efforts of a proven technological industry and the long list of capital equipment advancements that have and will inure to the benefit of all. With clearly stated policies, goals and objectives, combined with proper incentives, private enterprise can continue with the need for effecting application and transfer of advanced technology in achieving lower costs of health care. We urge Congress to continue support for the comprehensive health planning goals of P.L. 93-641 and, if necessary, to consider more practical alternatives to the stated purpose of S.1391.

Thank you for the opportunity to present our views on this very important subject.

Sincerely,

Robert G. McCune

Robert G. McCune
Division Manager

[1]J. Lloyd Johnson & Associates-"The Demand For Computed Tomography and Impact on Diagnostic Imaging Market." (Aug.1976)
Technicare Corporation-"Perspective on the Cost of Medical Technology." (May,1977)

RGM:ev

Resurrection Hospital

7435 W. Talcott Ave.
Chicago, Illinois 60631
Tel. 774-8000

May 11, 1977

U.S. Senator Edward M. Kennedy
431 Russell Senate Office Bldg.
Washington, D.C. 20510

Dear Senator Kennedy:

Enclosed is a copy of the written testimony of Resurrection Hospital regarding the Hospital Cost Containment Act of 1977. We would appreciate your evaluating this testimony prior to voting on that piece of legislation. We feel that such analysis will convince you that this legislation is not in the best interests of the hospitals, their employees and the American Public.

Sincerely yours,

Sister Bonaventure C.R.
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TESTIMONY OF
RESURRECTION HOSPITAL

SUBMITTED to the JOINT HEARINGS of
THE INTERSTATE and FOREIGN COMMERCE SUBCOMMITTEE on HEALTH
and the WAYS and MEANS COMMITTEE on HEALTH

regarding the HOSPITAL COST CONTAINMENT ACT of 1977 (H.R. 6575)

Resurrection Hospital is a 442 bed acute care hospital owned by Resurrection Hospital Association, an Illinois Not-for-Profit Corporation, and operated by the Sisters of the Resurrection, Immaculate Conception Province (Western Province).

We are cognizant of the problem posed by the ever increasing burden that health care is placing on our society. As an employer as well as a provider, we have seen the cost of our employees health insurance increase at a rate which exceeds the overall cost of living. As a provider, we are also aware that much of this cost increase has resulted from the changing nature of the service we deliver; that is the service we deliver today is more intensive and comprehensive than it was ten years ago. We support the idea of finding an equitable solution to this problem, however we feel that the proposed Bill will not accomplish the task in a manner that is equitable to the hospitals, their employees and the patients.

The Hospital Cost Containment Act of 1977 is intended to be a transitional act. Not enough questions have been answered nor enough analysis performed to allow this legislation to take effect. The piece of legislation will do much more harm than good. In addition, it will set some precedents which could destroy the voluntary hospital system in this country.

95-195 O - 77 - pt. 2 - 46

The law does not define or establish a national health policy. The present administration criticized the former administration for a failure to have a comprehensive energy policy. This administration has no health care policy. However, this administration has proposed a piece of legislation which will result in a de facto health policy for this nation. The subject of a national health policy can only be resolved in a de jure manner. The consequences of such a policy on the health services in this country must be faced directly. The public must be fully informed as to the nature of this policy. Determining a course of action prior to determining the necessary result is imprudent, whether it be for expediency or for political reasons.

A national health policy must determine what constitutes adequate health care. This is indeed a complex question which contains many sociological and moral overtones. To a native in the jungles of New Guinea adequate health care may consist of the absence of pain, adequate food and shelter. To a wealthy American who is the parent of a child with an immunological disorder adequate health care may require an expensive isolation chamber in order that the child might survive. Obviously the cost of the two expectations differs greatly.

Medicine has made and continues to make many advances. Some of these are dramatic and some are very subtle. The utilization of these advances by the American people costs money. Medical advances tend to be cumulative; that is, they are in addition to the existing

range of treatments and services. As an example; if a cure were found for an incurable disease this cure would not replace existing services to any great extent. The new service would be used by and dollars spent by people who would otherwise be dead and unable to expend money on health care.

For each disease and ailment that we conquer the average life expectancy is increased. Man, being mortal however, eventually succumbs to some other condition which he desires to ameliorate. The potential demand for new services appears to be infinite; for what person would not be in favor of spending money on a cure for a condition that he knew would eventually take his life.

At the present time the unstated health care policy of the United States is that any American is entitled to any and all advances that medical science is able to make. This policy may well be the required one for this nation. It must be acknowledged, however, that these expectations have contributed significantly to the rising health care costs in this country.

At this point it might well be pointed out that this Bill is intended to deal with efficiency and economy and not to establish any national health policies. The result of this law will be to establish a de facto health care policy. Thereafter, this policy will limit and reduce yearly, the amount of money expended on health care developments. Any administrator can assure you that some of the first items that are cut from a hospital's budget will be new services

that the hospital is currently not offering. The reason for this is that they are the easiest adjustments to make.

The law appears to allow exceptions for these new services. These exceptions are limited in their amount and they may not cover the full cost of the new service. If the hospital cannot afford these new services, they will not be implemented.

The proposed legislation does not deal with the question of what the full financial requirements of a hospital are. The Act would make a determination of how much the hospitals are to receive without any determination of what they need. The formula prescribed in the Act is not based on any substantial documentation which would indicate that it meets the hospital's financial requirements. The result of such an arbitrary formula could be financial disaster for the nation's hospitals.

A determination of full financial requirements should include the following items:

1. The appropriate level of operating expenses.
2. Recognition of any charity care and bad debts.
3. Debt Service.
4. A surplus to provide funds for the increased cost of replacement of assets.
5. A surplus to provide funds for the purchase of new equipment and start-up costs for new programs.
6. Sufficient revenues to maintain working capital.

It is interesting to note that the fifth item, funds for the purchase of new equipment and for new services, is dependent upon a national health policy if it is to be quantified.

Most people would probably not argue with our characterization of these requirements. The problem results when we attempt to quantify these factors. I submit that the administrations proposal that the GNP deflator is correlated to these costs is wrong. It is an economic average and therefore cannot be based on, or related to, the financial requirements of hospitals.

We are not proposing that there are no inefficiencies in the operation of hospitals. Hospitals, as with all industries and even government, have much room for improvement. We recognize this today as we have for several years. At Resurrection Hospital we have been evaluating these problems for several years. We have developed a sophisticated budgeting system which provides a wealth of information on our operation. Deviations and proposed budget supplements are reviewed; money is not expended; or corrective action is taken as a result of such analysis. We are continually looking for new ways to handle existing tasks. Our Department Heads have been changed from a status of unawareness of the cost of their operation to a position of scrutinizing that which their department spends. Many problems require months or even years of planning and study to resolve. We feel that the proposed retrospective control program places a degree of uncertainty in our planning process which could be disastrous.

Uncertainty in the planning process can only be reduced if any rate control legislation is completely prospective in nature. Once a rate has been established, it should remain in effect without being subject to refund or roll back. The same rates should be applied to all classes of payors so that one group does not carry the burden of the other's deficiency. The system should not automatically doom a pre-determined percentage of the hospitals to failure.

The hospitals rates should be based on peer group comparison. This will insure that the more efficient hospitals are not penalized. The individual hospital's ability to prosper should be totally dependant on its capacity to operate in a fashion which conforms to other hospitals.

Prospective rate setting which is not dependent on a hospital's "base period" tends to minimize its responsibility for uncontrolled factors. Thus, if the cost of supplies rise it is a factor all hospitals would have to encounter and it would be properly reflected in the peer groups prospective costs. The differences in cost among hospitals in a peer group would primarily consist of differences in controllable costs. If the hospital failed in this circumstance it would primarily be the result of its management's inability to deal with controllable elements. This would be an equitable result.

There are many factors in the operation of a hospital which cannot be controlled by its management. These include the cost of

supplies and services, professional liability insurance, and the fact that hospitals do not and cannot practice medicine. These circumstances can be very frustrating to a hospital administrator. Although not controllable the administrators of most hospitals are trying to influence, change, or make an optimum choice. At Resurrection Hospital we participate in two different group purchasing programs. The hospital drastically reduced its professional liability coverage in order to save money. We are continually encouraging the medical staff to make more effective utilization of the hospital; we have devised several new techniques for their consideration in utilizing the hospital. We will continue our efforts to influence these uncontrollable elements.

If these uncontrolled elements have such a bearing on the cost of care by whom or how are they to be controlled? The cost of goods and services are an economic matter; they can only be handled by the workings of the economy. The result is heavily dependent on the federal government's policy and the degree to which it tolerates inflation. Malpractice insurance is a problem which needs to be addressed as a matter of public policy, probably by the state governments. The physician's role in the delivery of hospital care is indeed a difficult one to influence. Professional Standards Review Organizations were designed to handle this circumstance. This mechanism is just beginning to operate and its effectiveness and usefullness have not yet been determined. PSRO has the capacity to influence physician behavior so that the patient care can be delivered

as effectively as possible. The Hospital Cost Containment Act will interfere with the effective operation of PSRO and will make an evaluation of them difficult.

Consideration as to what is ordered, how much is ordered and how long a patient is hospitalized should be made solely on a basis of medical necessity. Once again, we are faced with the question of health policy to determine what is necessary. It should be apparent that cost is a function of medical necessity and not medical necessity a function of cost.

We hope this doesn't appear circuitous, as a simplified corollary, we offer the following: Suppose a person is suffering from severe allergies. The medical care necessary to treat the ailment cannot be altered by reference to the person's ability to pay, but the correct treatment, in this case, perhaps a weekly injection, will determine how much it costs to treat the ailment. The need or desire for an injection is not controlled by a third party who administers the injection.

We used the word "desire" in the last sentence. The public's desire and expectations have contributed greatly to the increase in hospital costs. It wasn't too many years ago that a Cancer patient was a lost cause. Little was done for such a patient except to relieve pain and make him comfortable. Medical science has learned to prolong this patient's life or, in a growing number of cases, to

cure him. The public expects that these measures will be taken with cancer victims. It would now be immoral not to fulfill these expectations and the nation's hospitals have provided the capacity to fulfill such expectations. This need could not be filled solely by utilizing the existing resources. Fulfilling of new expectations requires the expenditure of money heretofore expended. Is it not apparent that if we are to continue to meet new expectations that the cost of hospital care, even with all inefficiencies removed, would be rising at a rate which exceeded inflation? The proposed legislation, by virtue of the mathematics of the inpatient revenue increase limit, will mathematically eliminate any differential in approximately three years time.

The rise in expectations has been accelerated by the Medicare Program, Medicaid and comprehensive insurance policies. Most of the public no longer directly feels the pinch of increased health costs. Patients constantly request additional "time" in the hospital to recuperate. Relatives request that the patient be discharged on Saturday so that no one has to lose a day's pay in order to pick up the patient. The physician fears a lawsuit if he antagonizes the patient. Utilization Review Programs have difficulty in determining just "one" extra day. The proposed legislation places the responsibility for this part of the hospital cost problem on the hospital.

The reimbursement mechanisms of all cost payor programs, including Medicare and Medicaid, are recognized to be ineffective.

They failed to reward hospitals who had encountered cost savings, they fully paid hospitals for mistakes in judgement. Certain elements of cost were not recognized, nor were the hospital's financial requirements. The cost payors rewarded inefficiency and penalized efficiency. The proposed legislation does nothing to correct the situation of penalization for the hospital who incurs a cost saving. The Bill claims that it provides incentives; there can be no positive incentive as long as such cost programs continue to penalize hospitals for their cost saving efforts.

The coverage provisions of most insurance programs including Medicare discourage utilization of outpatient services. Preventive medicine is usually not covered. Pre-admission testing is frequently not covered or if covered the requirements are extremely strict. These problems must be resolved if patients are to be encouraged to seek care in a cost effective manner.

The Hospital Cost Containment Act of 1977 contains a provision which we at Resurrection Hospital find extremely disconcerting. This is the provision which allows the Secretary of HEW to require that a hospital receiving an exception be required to implement any operational recommendations which he finds necessary in the interests of efficiency and economy. Quite frankly, we consider this to be a threat to the existence of the voluntary health care system.

Despite some problems and the admitted capacity for improvement the persons most able to determine the course of action for the

nation's hospitals are the directors and administrations of those institutions. They have the experience, training and ability to manage the hospitals. The ability of the government to make the operational decisions could lead to de facto nationalization of the industry.

Mr. Califano, at a press conference on April 25, 1977 was involved in the following exchange. Reporter's question, "Why not impose item-by-item limitations on services instead of just what the plan seems to do, which is to tell the hospitals to tighten up their budget?" Mr. Califano, "Going back to the prior question, because I do think there is a limit in the wisdom in the Federal Government and the ability which we can go item-by-item." If he questions the capacity to control prices item-by-item, how can he feel confident to make much more complex operational decisions.

The voluntary health care system has a long and noble history in the United States. This system was developed at a time when such a venture was risky. It contains the dreams of many dedicated nuns, brothers, other dedicated religious groups and concerned citizens. They saw a need which other groups, including governments, were not interested filling. It has endured because it did and still does serve the people. The voluntary health care system must be preserved.

The voluntary health care system is disappearing in many countries of the world. This has resulted from two different factors: first, a difference in moral philosophy between government and some of the voluntary institutions; second, because of a determination

that the government was wiser than the institutions.

If the voluntary system is to survive in the United States, the following assurances must be contained in any significant health legislation.

1. No hospital will be required to perform or allow to be performed any acts which contravenes its moral philosophy.

2. No hospital will be discriminated against, directly or indirectly, because of its moral philosophy.

3. The ratio of non-governmental controlled beds to governmental controlled beds will not be reduced after any peice of legislation.

4. Management's perogatives will be preserved.

We submit to you that these assurances are not only wise and equitable but are also the American way, and I am sure that the omission of these assurances from this piece of legislation was inadvertent.

In analyzing this Bill, we find that one assurance provided therein is insufficient. This is the provision that allows a pass-through on wage increases for non-supervisory personnel. Unless the entire economy is controlled it is patently unfair to subject these employees to the consequences of the hospital's financial hardships. The wage of the average hourly hospital employee today is still below that prevailing in the other industries. Much of the increase in

hospital costs over the past 10 to 20 years has resulted from an effort on the part of the hospitals to catch up. This effort could be undone in a short period of time. These employees deserve an equitable wage and many institutions, such as Resurrection, are committed to that proposition. These people cannot afford to be left behind. We propose that, as long as the rest of the economy is uncontrolled, the amount of wage adjustments to these employees be totally eliminated from any calculations or formulas involved with a retrospective revenue control program enacted.

Title II of the Hospital Cost Containment Act of 1977 places a financial cap on the nation's capital expenditures in the hospital industry. This provision will interfere with the operation and evaluation of the Health Systems Agencies established by the Public Health Service Act.

The Health Systems Agencies and the State Health planning and development agencies have not been given an opportunity to rectify the problem of proliferation of beds and costly equipment. The determinations made by them should be based on the area's health care needs. Title II will eliminate their capacity to make need determinations and make them rationers of a scarce commidity. It will impair their ability to develop comprehensive plans. A future determination of the effectiveness of health planning will be difficult, because it will be impossible to determine whether the reductions resulted from effective health planning or from the arbitrary cap.

We will gain no experience in determining our capacity to meet the health care needs of our citizens. This will make it more difficult to deal with the needs defined by any national health policy.

The Public Health Service Act has the capacity to accomplish the goals of Title II and without attempting to make medical necessity a function of cost. The decision of Congress to establish the current health planning system should not be obliterated by the enactment of the Hospital Cost Containment Act of 1977.

In addition to this testimony, we are submitting an analysis of Title I of the Hospital Cost Containment Act of 1977. This analysis deals with the mechanical provisions, clarity and construction as we perceived them. Although it does not reveal all the problems, it does indicate that the Act is extremely complex, obscure and creates the potential for many unforeseen problems. We would hope that these observations would be seriously evaluated. These problems are serious enough to require that this legislation be replaced with legislation which will meet the needs of hospitals, their employees and the patients.

ANALYSIS OF THE PROVISIONS OF TITLE I OF THE HOSPITAL COST CONTAINMENT ACT

PREAMBLE

The Bill is intended as a transitional system; if it is transsitional why doesn't the legislation have a termination date? This legislation can do a great deal of harm in a short period of time, if it were inadvertently allowed to remain in effect for any long period the result would be catostrophic.

SECTION III

Section III provides no incentives for hospitals who come into the control program with per admission costs or changes lower than the majority of Hospitals in their "class". These hospitals already have less fat and inefficiency and it results in their being the "hardest hit" by the program.

The limits imposed by Section III are to be applied retrospectively. Ultimate costs or charges per admission will not be finalized until the accounting year is over. This results from many factors including: subtle changes in case mix, deviations in occupancy less than those recognized by the admission load formula, technological advancements, and unpredictable intensification.

The proposed formula will result in many unintentional and unavoidable violations.

The controls are imposed on a "per admission" basis. There is no recognition built in for changes in case mix. Such a system erroneously assumes that hospitals control the length of stay and the determination as to what services are rendered to a patient. Hospitals' accounting and billing systems are not designed around the admission concept; thus the formula will create a bookkeeping nightmare.

The adjustment (Section III(a)(1) from the 1976 fiscal year to October 1, 1977 does not recognize new services which may have been implemented during that period.

For hospitals whose fiscal years are not October 1 to September 31, the formula prescribed will control the hospitals' revenues during a period which is prior to the effective date of the law. In many cases the effective date of the controls will predate the passage of the Act. This would appear to be ex post facto and therefore unconsitutional.

SECTION 112

Under Section 112, the GNP deflator to be used for a prospective period is a retrospective figure. Although the Section allows for a change in the formula for unusual increases in the GNP deflator, such

adjustments will not be made in time for them to be reflected in the hospital's charges.

Although the determination of the In-patient hospital revenue increase limit is to be determined (according to the bill) between July 1 and October 1 of each year, the Administration has "announced" that it has already determined the figure (9%). How would 9% have been determined when the bill requires that the June 30 GNP deflator be used in making the calculation.

Section 112(b) (B) (i) does not define "total hospital expenditures"; nor is it clear whether the increase in such expenditures is to be measured on a gross or per admission basis.

Section 112(b) (B) recognized "one-third" of the historical difference between cost increases in the hospital industry and the entire economy as reflected by the GNP deflator. This one-third factor is arbitrary and constitutes a significant policy decision on the extent to which medical research and advancements should be limited. Such a policy should not be established without completely examining all of the consequences of such a limitation. If such a limitation on advances needs to be made, it should be directly acknowledged and with recognition of the effects on the future advancements in health care. The methodology of policy setting is indirect, and it will not serve to directly inform the public of the consequences of their representative's actions.

Section 112(b)(B)(i) requires a measurement of total hospital expenditures for a 24 month period ending on a December 31. With hospitals on many different fiscal years, this figure is not currently accumulated in any accurate manner. This could result in an additional reporting burden for the hospitals.

SECTION 113

The admission load formula makes it practically impossible to set prices. Any minor change in admissions requires an adjustment if total revenues are to be maximized or a violation avoided. It is unrealistic to expect hospitals to exactly predict what their admissions will be.

The formula fails to allow for or give recognition to changes in the percentages of each class of payor served by the hospital. Each class of payor pays a different price. If the percentage of cost payors declined and the charge payors increased there would be an increase in total revenue (cost payors usually pay less than charges). The hospital should not be subjected to a potential penalty as a result of the type of insurance coverage carried by its patients.

The admission load formula is arbitrary and cannot be supported by recognized factual data. It tends to make the touted 9% control illusory. A hospital whose admissions increased by 2% would appear to be eligible for a 7% increase in prices and costs.

Under Section 113(3) there is no additional revenue allowed for increased admissions above 15% of the base year, but there must be a dollar for dollar reduction for decreases greater than 15%. If it is assumed that increases greater than 15% incur, no additional cost, it must be assumed that decreases greater than 15% save no additional costs.

If there is a violation of the total revenue limit, the Act does not explain how to apportion such excess to the various classes of payors for the purpose of rebates or roll backs.

SECTION 114

This Section does not adequately define the revenue base. It is unclear as to whether or not bad debts, free services and contractual allowances are taken into account. It appears to require the adding of reimbursable costs to gross patient charges but such a calculation is duplicative.

SECTION 115

Under Section 115(a) (1) there are no guidelines as to how inpatient costs are to be calculated for the purpose of requesting an exception. There are numerous methodologies for calculating cost, all of which lead to a different result.

Under Section 115(a)(1)(B) changes in the capacity or character of service are allowable only to the extent they exceed (on an admission basis) more than one-third of the difference between the rise in hospital costs during the preceding two calendar years and the GNP deflator during the previous two calendar years. Thus, even with an exception, a hopsital could incur thousands of dollars of new techology costs for which it could receive no reimbursement under any circumstances.

Under Section 115(a)(2) hospitals who are in financial difficulty appear to be eligible for an exception. The paragraph ends with the word "and"; thereafter paragraph 3 begins. The implication could be made that in addition to being in financial difficulty, a hospital would have to be incurring the conditions specified in paragraph 3 in order to receive an exception. For example, is it possible that a hospital whose current ratio was in the lower 25 percent of all hospitals but who was found not to have been generating "excess costs" described in paragraph 3 could legally be denied an exception?

Section 115(a)(3)requires that the State Health Planning and Development Agency make a finding that changes in admissions be found necessary. A change in admissions which results strictly from changing utilization of an existing facility and not currently subject to review by the planning agencies; in fact the agency if submitted with such a proposal would make a finding of non-reviewable. As this paragraph is constructed, the following would appear possible; a hopsital's occupancy could drop from 90% to 70%, the State Agency would not have made a determination of the need for such a decrease in that institutions

admissions and thus the hospital would not be eligible for an exception because Section 115(a) (3) requires a need determination as a condition of an exception being granted.

Section 115(a)(1)(A) provides for an exception for hospitals whose admissions change beyond the range specified in Section 113(3). Then if an exception is granted, the allowed revenue shall only be the amount that would have been allowed a hospital in the same circumstance which had less than 4,000 admissions. There is no basis whatsoever for determining that such an amount is relevant to the excepted hospital's need.

Under Section 115(b) the methodology for applying for an exception is established. It requires that the application be filed in a form and manner prescribed by the Secretary. If such regulations are not established and promulgated by the implementation date of the law, it would be impossible for a hospital to make a valid application. The effective date of the law must be contingent upon the availability of an exception procedure, a failure to do so is a denial of due process.

Section 115(d)(2) establishes the duration of an exception which was based on financial hardship. This provision erroneously presumes that a current ratio can accurately be predicted on a prospective basis. The limit on the relief provided makes it difficult or impossible for a hospital to develop its financial condition to a viable position. In short, those hospitals with a poor financial condition will have to stay that way.

Under Section 115(c) a hospital which receives an exception must make itself available for an operational review by the Secretary. In addition, the exception is contingent upon implementation of any recommendations made. The number and type of demands which the Secretary could require under this section are unbridled. There is no assurance that a hospital will not be required to violate its moral standards. There is no assurance that this device can't be used to eliminate management's prerogatives; indeed there is no assurance that he can't require a change in management itself if he feels it would make the hospital more economical and efficient. Indeed there is no assurance that this provision could not result in the destruction of the voluntary system as we know it. This provision is an affront to the American Way of Life and our system of government. Any legislation which allows the government to interfere with operational decisions borders on nationalization of the industry. If the Voluntary Hospital system is to survive the following assurances must be provided in any federal health legislation:

A. Operational Decisions will remain the prerogative of the hospital's management.

B. A Conscience Clause which will insure that no institution will be required to violate its moral standards and in addition will not be penalized in any way for adhering to its moral standards.

C. That the voluntary system survive by requiring that the ratio of non-governmental to governmental hospital beds remain the same after the enactment of any federal programs as the ratio of voluntary to governmental hospital beds that existed prior to any such legislation.

SECTION 116

Section 116 prohibits the payment, on an interim basis, by any cost payor of an amount which would exceed the applicable limits established by the law. Because of the nature of the regulations, compliance or non-compliance with the limits can only be determined after a fiscal year is completed. It is impossible to accurately determine on a prospective basis what average charges or costs per admission will be; or if admissions will exceed the allowable corridors established by the admission load formula thereby requiring an adjustment to the per admission "price". Hospital bills are rendered and paid on a case by case basis either by a per diem method or a line item method of payment. Any individual hospital bill will not conform to the "average" per admission. How, therefore, is it possible to determine how much is to be paid on any individual patient bill. The only solution for the cost payor is to underpay, on an interim basis, in an amount the payor feels will insure that Section 116 is not violated. This will create serious cash flow problems for the hospitals. Hospitals will be forced to borrow in order to finance current operations. This increased borrowing results in interest expense which is not necessary. The interest expense is a component of cost which was not in the base accounting year and therefore will require that a portion of the revenue available under the "adjusted in-patient hospital revenue increase limit" be wasted on an unnecessary expense.

Section 116(d)(2) provides for the exemption from penalties if the hospital places into escrow the amount of the violation which

is not applicable to cost payors. The amount remains in escrow, "until such time as charges below the applicable limits established under this title, equal in the aggregate to such amount, are experienced". Changes are imposed in specific items of service, the limits are imposed on average amounts per admission. It is therefore impossible to accurately determine when you have reduced charges on specific items of service for sufficient period of time so that when average charges per admission are thereafter measured that you are sure you have "lost" the correct amount. For example, assume that a hospital determines that it must return $50,000 by reducing the room rate by $10 per day for 5,000 patient days; and further assume that the determination was based on an average admission cost of $1,000 and an average length of stay of 8 days. The hospital anticipates 60,000 non cost payer days for the year. After one month the hospital would have lost the anticipated required amount. After the year proceeds the average length of stay increases to 8.4 days as a result of a significant change in case mix. Instead of an average case cost of $993.33 (625 admissions X 920 + 6875 admissions X 1000) --(7500 total admissions) as was anticipated the average case cost would be $1,043.33. (625 admissions X 970 + 6875 admissions X 1050)--(7500 total admissions). Not only would the hospital have failed to make the required roll back but it would have also exceeded its inpatient hospital revenue increase limit. These problems would be encountered even though the institution made a bona fide effort to correct a previous excess.

The roll back provided in Section (d)(2) is intended to correct overcharges made to non-cost payors; that is those persons who pay charges. The result of the methodology prescribed therein could result in a benefit not only to the charge payors but also to the cost payors. This results from the fact that most cost payors are on a lower of cost or charges basis. The cost payors would have already limited their payments to the adjusted inpatient hospital revenue increase limit during the previous year. As a result of the charge roll back during the current year the charges could become less than the cost. As a result, the cost payors would be allowed to pay less than the current years adjusted inpatient hospital revenue increase limit. They would be receiving a partial second rebate. This would exacerbate the hospital's financial problems.

Section 116(d)(1) relates to the Secretary's determination of a violation of the average charges per admission. Reference to 116(d)(2) indicates that this is to be calculated by dividing total inpatient hospital gross revenue by total admissions. These totals include both cost and charge payors. The previous section of the act indicates that compliance is determined according to class of payor. The result of the 116(d)(2) methodology could be the determination of an excess, which determination might not exist if the analysis were made by dividing gross charges to charge payors by charge payors admissions. On the other hand, the opposite could occur; no excess would be determined by calculating on a total basis but would be determined on a charge payor basis.

SECTION 117

Section 117 allows for exemption for Hospitals in states which have an "adequate" rate control program. The end result of this section would be to prohibit a state from developing its own program unless it literally followed the federal act. Although Section 117 appears to provide an alternative; the availability of an alternative has effectively been preempted by the nature of the Section itself.

Section 117(a)(2) requires that any alternative state program apply to all payors except Medicare. One of the problems with the development of state rate programs has been the fact that Medicare could not be covered. This position also ignores the fact that Medicare itself has been a major contributor to the conditions that the Hospital Cost Containment Act is trying to rectify.

SECTION 121

Section 121(b) exempts Federal Hospitals from the provisions of this act. This is ironic insofar as the cost of government has increased at a rate that is also alarming to the public.

SECTION 124

Section 124 attempts to insure that hourly wage earners will not be denied increases as a result of this legislation. For this

section to have any impact it is necessary to first provide increases to the employees which equal the ratio of hourly wages to total costs times the adjusted inpatient hospital revenue increase limit. After that "base" level has been granted, a pass through would be available. If the hospital is unable to afford the base level there is no opportunity for a pass through.

Section 124(d) is poorly constructed. Despite the explanation of the administration it is possible to read this paragraph two ways. One way is to interpret it as requiring that the pass through is not available until after March 31, 1979 and then it is contingent. The other way is to interpret it as requiring that the continuance of the exception after March 31, 1979 is contingent.

This section fails to recognize wage related costs which must be increased whenever the wage itself is increased. These costs consist both legally mandated benefits and discretionary benefits.

SECTION 125

Section 125 requires that certain financial information be disclosed to the Health Systems Agency in order that it be made public. The requirement that a small selection of prices be disclosed is meaningless to the public. For one reason it does not give an adequate indication of the cost of a hospital stay. For another

thing, these charges may have absolutely no bearing on what the cost payors pay the hospital. These cost payors may constitute the majority of the hospitals revenues. It will deceive the public into believing that Medicare, Medicaid and Blue Cross are paying more for the care rendered a patient than those payors actually must pay.

SECTION 126

Section 126 places the Health Systems Agencies in a position of having to perform inappropriate law enforcement functions. This entire section is rife with potential constitutional questions. The concept that a hospital could incur penalties solely on the basis of a justifiable complaint is tantamount to sending a person to jail because of an indictment.

SECTION 128

Section 128 amends the Internal Revenue Code to provide a 150% excise tax on amounts paid by cost payors or received by hospitals in excess of the amounts allowed under the act. Because the tax is punitive and because it is avoidable it is doubtful that it is in compliance with the Congress' taxing power.

SCIENTIFIC APPARATUS MAKERS ASSOCIATION

June 23, 1977

Hon. Edward M. Kennedy
Chairman, Subcommittee on Health and
Scientific Research
Committee on Human Resources
United States Senate

Dear Senator Kennedy:

Enclosed is a statement of the views of the Scientific Apparatus Makers Association on S. 1391, the Hospital Cost Containment Act. The statement is submitted for inclusion in the hearing record.

I would like to thank you for this opportunity to express our views to members of the Senate.

Yours truly,

John F. Rodgers
Director of Government Affairs

JFR/avl
Enclosure

1140 CONNECTICUT AVE., N.W., WASHINGTON, D.C. • 20036 • 202 - 223-1360

STATEMENT OF THE SCIENTIFIC APPARATUS MAKERS ASSOCIATION ON S. 1391, THE HOSPITAL COST CONTAINMENT ACT, Submitted to the Subcommittee on Health and Scientific Research of the Committee on Human Resources, United States Senate

This statement expresses the views of the Medical Devices and Diagnostics Section of the Scientific Apparatus Makers Association (SAMA) regarding S. 1391, the Hospital Cost Containment Act of 1977. The membership of SAMA's Medical Devices and Diagnostics Section consists of approximately 50 companies engaged in the manufacture and distribution of in vitro diagnostic reagents and instruments, patient monitoring and related electro-medical equipment, and ophthalmic instruments.

SAMA wholly subscribes to the view that the rapidly escalating hospital costs experienced in the last decade are a matter of national concern. There is a need for well-directed programs to contain the rate of health care inflation within sound limits without causing deterioration in the quality of health care provided. While this is the stated purpose of S. 1391, SAMA is of the view that it contains defects that unless corrected will not contribute to the achievement of this goal but rather make its attainment more difficult.

SAMA's chief concern is with Title II, which would arbitrarily restrain new capital expenditures by hospitals. Unquestionably there have been unwise capital expansions in health care facilities which have contributed to excessive cost inflation. Generally these expenditures have been made for the purpose of providing increased capacity or new services purported to improve the quality of care available. Clearly whether new capacity and new services are sufficiently needed to justify their cost should be carefully reviewed.

On the other hand, one of the principal purposes of a capital expenditure is to finance a new means of accomplishing an existing function at an improved cost. Hospitals are labor intensive institutions, with labor costs accounting for about 60 to 70% of total costs. Experience has indicated that capital investment in automation provides the most promising means of achieving cost savings in labor intensive industries and history has proved this to be true in the case of hospitals. The contribution of automation and improved techniques

to reducing the costs of diagnostic procedures provides one of the best cases in point. New automated instruments now being used are performing tests with greater accuracy and reliability at a fraction of the cost of the manual procedures they replaced. SAMA members are justifiably proud of their record in providing innovation that improves both the quality and cost of health care. Such savings could not be achieved without substantial capital investment, and it appears that more innovative labor-saving technology is being developed that holds out much promise for substantial savings in hospital labor costs.

Clearly capital investment providing more efficient performance, as distinguished from that merely increasing capacity or adding new services, should be encouraged. However, by arbitrarily restraining all capital investment, S. 1391 will make it more difficult for hospitals to invest in labor-reducing cost saving systems. Investment in cost saving equipment has fewer champions in the current health care community than investment in additional or purportedly improved services and this is likely to be true regardless of whether or not there is a limit on hospital charges. Thus investment in cost saving automation will be disadvantaged in competing for a share of limited hospital capital investment funds, and the effect of the S. 1391 limit on capital expenditures may be counterproductive to the goal of achieving improved cost performance.

SAMA submits that there already exists a sound program for directing health care capital investment under P.L. 93-641, the Health Planning and Resources Development Act of 1974. Additional resources should be put into the implementation of this law. The arbitrary capital investment limit proposed in S. 1391 would require a reevaluation of much of the work that has already been done to implement P.L. 93-641 and delay the implementation of a sound plan for evaluation of hospital capital investment.

Another better approach to controlling unwise capital investment is a system of prospective reimbursement that rewards efficient performance and penalizes inefficient performance. This is the approach taken in the legislation sponsored by Senator Talmadge, S. 1470, and SAMA would endorse such legislation in concept although not in detail. Clearly, however, it is important that cost containment legislation produce an incentive for cost saving investment as S. 1470 does, rather than the disincentive contained in S. 1391.

# # #

SCHA south carolina hospital association

william l. yates, executive director

June 17, 1977

Stuart Shapiro, M.D.
Subcommittee on Health and Scientific Research
Committee on Human Resources
U.S. Senate
Washington, D.C.

Dear Dr. Shapiro:

The South Carolina Hospital Association submits the attached statement on S1391. We respectfully request that our statement be incorporated into the record of the Subcommittee on Health and Scientific Research, Committee on Human Resources, which has been conducting hearings on this legislation.

Sincerely,

William L. Yates

WLY/lo

Enclosures

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STATEMENT OF THE SOUTH CAROLINA HOSPITAL ASSOCIATION TO THE SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH OF THE SENATE HUMAN RESOURCES COMMITTEE ON S. 1391, THE HOSPITAL COST CONTAINMENT ACT OF 1977

The South Carolina Hospital Association shares the nation's concerns over rising hospital costs. From this concern, and from the overall concern for the quality of life and health of the people we serve, springs our strong opposition to S. 1391. The opposition of hospitals in South Carolina to S. 1391 is manifold, because of the numerous inconsistencies, injustices, and complexities included in the proposed legislation. The major concerns of this Association and its members are as follows:

1. The legislation will not accomplish the goal of containing the increasing costs of health care in the United States; rather it will result in reduction of hospital services and will produce inefficiencies in the delivery of health care, not promote efficiency.
2. The legislation ignores the primary purposes of hospitals, which are: to provide diagnostic and restorative services to the sick and injured in society; to provide communities a cost-effective system for ensuring the availability and optimum use of specialized health care services by concentrating technology and highly skilled manpower in one setting; and to enhance the productivity of physicians in caring for individual patients by making available centralized equipment, facilities and personnel for diagnosis and treatment.
3. The legislation would usurp the rights of communities and citizens to determine the scope and level of health services appropriate to meet their needs and the optimal allocation of existing resources to meet identified health care needs.
4. The legislation singles out a single provider of health care - the hospital - for control, and, in so doing, ignores basic economic principles and the basic freedoms generally accorded to community institutions.
5. The legislation ignores the factors responsible for increasing hospital costs.
6. The legislation ignores the current financial situation of hospitals in this country.
7. The legislation ignores the role that government itself has played in increasing hospital costs, and proposes another layer of regulation on an already over-regulated field.
8. The legislation ignores the differences between hospitals and the differences between states and between regions.
9. The legislation ignores existing mechanisms designed to promote optimum use of hospital services and to eliminate unnecessary duplication of services and facilities; specifically, the Professional Standards Review Organizations and the Health Systems Agencies.
10. The methodology for implementing the program is obscure, poorly defined, and unwieldly.

In support of the above ten points, the South Carolina Hospital Association offers the following observations.

The proposed legislation, as many legislative and regulatory programs which have preceded it, addresses only the supply side of the supply-demand equation in the health care cost issue. The legislation will force institutions to limit inpatient services to those which can be provided through allowable inpatient revenues. Inasmuch as the costs which hospitals must pay for manpower, food, fuel, professional liability insurance and supplies have been increasing at a rate faster than the GNP deflator, and the proposed legislation calls for a gradual reduction in allowable inpatient revenue increases until such increases approximate the GNP deflator, a cost-revenue imbalance is inevitable. When this occurs, and for many hospitals in South Carolina it will occur rapidly, inpatient services will have to be curtailed in some way.

If hospital inpatient services are curtailed, and there is no abatement in demand for health care services, obviously other mechanisms for meeting demand for health care will arise. These are most likely to arise in unregulated sectors of the health care field and will inevitably result in duplication of high cost equipment and services outside the hospital; in fragmentation of care; and in reduced efficiency in the provision of care. Through this process, the costs of providing health care services will be transferred from the

inpatient hospital setting to other settings, but a reduction in the nation's total cost of providing health services is unlikely. If the federal government realizes some savings in total Medicare and Medicaid payments to hospitals for inpatient care, these savings will be realized only through costs transferred to individuals and other third parties who purchase health services in alternative settings. This transfer of the location of services will cause higher costs in both hospital inpatient units and in alternative settings. The former will occur as all but the most acute cases are transferred to outpatient care, causing even greater intensity of services required for inpatients. The latter will occur because of unabated demand for outpatient health care services in a variety of unregulated locations.

The introduction of S. 1391, with accompanying comments by Secretary of HEW Joseph Califano, would suggest a lack of understanding of the purposes of hospitals and the nature of their ownership, control and financing. In addition to providing a centralized location for highly complex technology which individual physicians may use in diagnosing and treating their patients, hospitals represent their communities' concern for the health and well-being of their citizens; a concern that is highly valued in American society. Hospitals, regardless of ownership, exist to provide services in keeping with the communities' needs.

Charges of obesity and recklessness are totally inconsistent with the purposes and operations of institutions created for fulfilling such a basic human need as the provision of compassionate health care services. While there has been rapid expansion of hospital services over the past decade, this has not occurred as a result of hospital desires for aggrandizement, but rather as a response to increasing demand for services, made possible by advances in medical science and technology. (Parenthetically, it should be remembered that government, through various programs, has contributed to increasing demands for health care and the development and dispersal of new technology in health care.)

The determination of the services to be provided by a given hospital is the responsibility of the hospital's board of trustees, those individuals charged with the moral and legal responsibility for administering and protecting public trusts or corporations established for the purpose of ensuring the availability of hospital services to the community. Planning decisions of such boards in South Carolina today must be reviewed by a Health Systems Agency and must be awarded a Certificate of Need before they may be implemented. This process is designed to ensure coordination of planning by hospitals within a region. In South Carolina, this process, while too new for full evaluation, has had considerable impact in curtailing planning construction and expansion. Appropriate use of inpatient hospital services is determined by the hospital's organized medical staff, under responsibility delegated by the Board, and in consort with the Professional Standards Review Organization. These programs have achieved a reduction in length of stay in South Carolina hospitals from 7.7 days in 1970 to 7.3 days in 1975.

Further governmental intervention in community and regional health care planning and health care delivery will reduce or eliminate the rights of communities to decide the level and scope of health services which are appropriate for their needs. It would have potential also for interfering in the private practice of medicine. If new technology considered by the private physician as necessary for the treatment of his patient were not available locally, the physician would either have to substitute a less desirable type of treatment or refer his patient elsewhere. Such existing control programs as PSROs and Certificate of Need should be given an opportunity to demonstrate their full potential before any decision is made to further abridge the rights of citizens, physicians and hospitals.

The proposed permanent controls on the capital expenditures of hospitals, as contained in Title II of the legislation, would tend to bring improvement and innovation in hospital care to a halt. The amount proposed to be distributed among the states is inadequate to provide for modernization and replacement of outdated facilities and the acquisition of new equipment. This provision would prevent hospitals from further progress in health care technology and new services and would seriously discriminate against hospitals in South Carolina, which are relatively undercapitalized. Assets per bed in South Carolina hospitals are approximately 1/3 lower than the national average.

Hospitals in South Carolina would welcome appropriate action by the federal government in responsible, cooperative efforts to contain increasing health care costs. Unfortunately, S. 1391 is an inappropriate proposal for it fails to address the underlying causes of these increases.

While the prices of goods and services needed by hospitals are a major reason for high hospital costs, inflation in the general economy continues to push these prices up making them an even greater problem for hospitals. Roughly 10 per cent of the overall increase in hospital costs nationally is attributable to inflation in the general economy. In South Carolina, it is slightly higher, inasmuch as many of the products hospitals purchase are obtainable only through national, rather than local markets. In addition, the general economy of South Carolina has been behind the nation for decades, but is now in a period of rapid catch up, causing higher-than-average increases in salaries, fringe benefits and the costs of local services. The revenue limits proposed in S. 1391 would seriously damage the ability of South Carolina's hospitals to attract managerial, supervisory and professional personnel. In effect, the state's hospitals would never be able to achieve even the national average salary level for hospital employees and would not be able to compete with other employers of professional and managerial personnel within the state.

Another factor which contributes to the high costs of health services is the growing public demand for these services. This demand has a double effect on hospital costs since it creates a need for more and more physicians and other health care professionals, and these people are often trained in hospital programs which are funded by patient revenues. The expense of modernizing, maintaining and intensifying services has also helped increase the costs of hospital care. And finally, the hospital's cost of complying with government regulations, many of which are duplicative or contradictory, adds to patients' hospital bills.

During this period of rapid economic growth in the state, South Carolina hospitals have made monumental efforts to contain costs through a variety of programs.

For example, hospitals in South Carolina are extensively involved in shared services, a recognized method of reducing capital investment for new services and controlling operating costs by economies of scale. The largest single example of shared services in this state is a non-profit corporation known as Carolinas Hospitals and Health Services, Inc. (CHHS) which offers services in industrial engineering, computerized productivity reporting, engineering support, group purchasing and comprehensive management. CHHS's Management Services Division provides to contracting hospitals in the two Carolinas an in-hospital director with a wide array of staff specialists in various management areas. A majority of hospitals in South Carolina voluntarily participate in one or more of these programs.

Other shared services have been developed by hospital groups within certain geographic regions or on the basis of common need. Six hospitals in this state have formed the Hospital Data Corporation to share electronic data processing equipment and services. In another region of the state, a large hospital shares nuclear medicine services, emergency medical services training, and continuing professional education programs with smaller surrounding hospitals. Numerous examples of this exist in the state because hospitals have a commitment to containing costs and to improving health care in the most economical way possible.

Also, the South Carolina Hospital Association and the South Carolina Medical Association are co-sponsoring a rural health delivery project, which is designed to increase the physician supply in rural areas and to expand ambulatory care and out-patient services in these areas. This project has the potential for reducing inpatient admissions in rural areas and improving the health care available to rural South Carolinians. The project is being funded by The Duke Endowment and The Self Foundation.

It is unthinkable to expect hospitals in South Carolina to absorb increasing costs of manpower, energy, food and supplies -- costs over which they have no control. Drafters of the legislation apparently were totally unaware of the financial condition of hospitals at the present. In 59 South Carolina hospitals assisted by The Duke Endowment, inpatient costs (that is, the costs hospitals expended in providing services to inpatients) increased 13.8 per cent from fiscal year 1975 to fiscal year 1976. In the same

period, adjusted inpatient revenue (hospital inpatient charges to patients minus contractual allowances for Medicare and Medicaid, charity and bad debts) per admission increased 13.4%. Adjusted inpatient revenues in both years were less than inpatient costs. In 1975, the adjusted inpatient operating margin was minus 7.06%, in FY 1976 it was minus 7.59%. Many public hospitals have found it necessary to subsidize inpatient care through contributions from philanthropic organizations and local government subsidies. S. 1391 would appear to treat local governments as a separate class of purchaser and, thus, would limit these subsidies in the future.

Philanthropic organizations are becoming increasingly unwilling to contribute funds to hospitals to subsidize inpatient care, since essentially these funds would be used to make up deficits caused in part by contractual allowances for Medicare and Medicaid.

The current financial situation of hospitals in South Carolina is a result of many factors. Many of these have been enumerated, but the greatest single factor has been the increase in demand created in most part by federal and state programs which pay less of their proportionate share for inpatient services than other third parties and private payors.

Another major factor has been the increasing number of regulatory programs affecting hospitals. Regulation of the hospital industry is pervasive and has affected almost all departments and operations. An ever-increasing amount of managerial time is required to interpret regulations which continue to change. A sincere effort to bring about cost containment in hospitals would entail elimination of all unnecessary and duplicative federal and state regulations affecting hospitals, but instead S. 1391 proposes another layer of regulation on the industry. As of this date, satisfactory explanations of the provisions of S. 1391, and clarification of terms used in the legislation have not been provided to the hospital field, but the proposal would most certainly require a new bureaucracy for administration and determination of compliance, as well as additional administrative, accounting, statistical and planning personnel for hospitals.

One of the major injustices in the proposal is the application of a single limit to all hospitals, regardless of location, service, or ownership, unless the hospital can prove it is approaching insolvency. Hospitals vary greatly in many respects, and especially in the scope of services and patient mix. In South Carolina, hospital charges to patients are considerably less than national averages, but percentage increases in charges have been higher because of the surrounding economic conditions previously explained. A nationally applied ceiling on percentage increases in revenues will forever discriminate against hospitals in South Carolina and in similar states. In addition, the controls would selectively discriminate against those institutions which attempt to provide a broad range of specialized services for the most acutely ill.

Finally, the legislation, if enacted, would produce serious managerial and financial problems for hospitals. Because of the time schedules included in the proposal, hospitals would not be able to utilize internal budgeting programs effectively, since allowable revenue would not be known at the beginning of the budgeting cycle. Further, continuous monitoring of admissions and charges would be required in order to avoid payback requirements or penalties. Most certainly, third party payors would attempt to limit payments to hospitals during the year to avoid penalties and would opt for year-end adjustments between actual payments and allowable charges determined at the close of the fiscal year. This would cause additional cash flow problems for hospitals.

This statement by no means is an exhaustive list of the inequities, injustices and administrative inefficiencies and problems which would be created by S. 1391. The South Carolina Hospital Association concurs with the conclusions of the American Hospital Association regarding the problems which would be created, as described in the Statement of the American Hospital Association presented to the Subcommittee on May 24, 1977.

The South Carolina Hospital Association would urge that appropriate alternatives to containment of hospital costs be considered, but does not support any programs which would result in duplicative regulatory programs, unworkable administrative requirements, or infringement on the rights of communities

in determining the level and scope of services available to them. It is the conviction of the South Carolina Hospital Association that further attempts by government to contain hospital costs by limiting the supply of hospital services will not only fail to achieve the objective of lower costs, but will also add unnecessary costs to an industry beset by inflation. The Association is convinced that government should direct its attention to the problem of increasing demand for "more" health care and for "perfect" health care. Hospitals and doctors today not only are expected to provide an increasing volume of sophisticated services, but they also are being held accountable for the unforeseen consequences of treatment provided ten and twenty years ago, such as the provision of certain drugs to prevent miscarriages, even though the care provided then was considered safe and effective by prevailing medical standards.

Until this demand for more and perfect health care is dampened by more responsible insurance mechanisms, both in health insurance and professional liability insurance, it is unreasonable to expect a substantial reduction in the rate of increase in total expenditures for hospital care. The federal government should encourage the development of more responsible insurance mechanisms and should require deductibles and co-payments in all governmental programs. Supplemental benefits to cover deductibles and co-payments should be prohibited or strongly discouraged. The use of co-payments and deductibles can serve as a strong incentive to motivate individuals to appropriate utilization of health services and to maintain and improve their level of health through changes in lifestyle. Any form of co-payment incentive must be designed to reflect differences in individual income levels and provision should be made to permit individuals who receive subsistance grants to exercise individual decision-making with respect to health and health care.

More responsible approaches to the professional liability insurance problems of health care providers must likewise be approached. While any injured individual should have a right to recovery, excessive awards and premiums unduly penalize patients and providers alike.

Finally, the South Carolina Hospital Association supports all reasonable approaches to eliminate fraud and abuse of governmental health care programs. The federal government should pursue this objective vigorously and should likewise refuse to contract with any institution or other health care provider which imposes charges the government deems to be excessive. Adequate mechanisms exist for the determination of excessive charges, through Medicare cost reports and Medicare audits.

6/16/77



SOUTH DAKOTA HOSPITAL ASSOCIATION

June 8, 1977

STATEMENT OF THE SOUTH DAKOTA HOSPITAL ASSOCIATION
TO THE
SUBCOMMITTEE ON HEALTH OF THE SENATE COMMITTEE ON HUMAN RESOURCES
ON S.1391, THE HOSPITAL COST CONTAINMENT ACT OF 1977

The South Dakota Hospital Association (SDHA) represents community hospitals in the State and serves, among other functions, as spokesman for 66 hospitals and related health care institutions in South Dakota. We appreciate the opportunity to submit written testimony to the Subcommittee on S.1391.

We know that the Subcommittees will receive considerable testimony of a general nature in opposition to the proposal from individuals and organizations throughout the country. It is our specific purpose in this testimony to relate the provisions of S.1391 and their impact to a rural, sparsely populated state such as South Dakota. In doing so, emphasis will be placed on what we strongly believe to be an eroneous conceptual basis for the proposal as well as the extremely complicated and unfair manner in which the requirements of the bill would be administered.

The Subcommittee, and, for that matter, any individual seriously considerning the real and complex problem of rising hospital expenses,

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must recognize that individual hospitals and groupings of hospitals in particular geographical areas vary dramatically in their size, scope of service, and inter-institutional relationships. To promulgate a uniformly applied, federal hospital revenue limitation is, as has been demonstrated repeatedly, inequitable and unworkable. To compound that conceptual error by making such a formula applicable to every hospital regardless of its size, location, scope of service, or relationship to other hospitals, seems, from our perspective, unthinkable.

Any "Cost Containment" proposal-including the present Administration proposal-must be assessed at the very least in terms of the nature and magnitude of the problem to be "solved"; the degree to which the "solution" addresses the "problem"; its administrative and logistical feasibility; and its degree of flexibility in addressing legitimate institutional or geographic differences. We are convinced that "The Hospital Cost Containment Act of 1977" especially and specifically when viewed from the South Dakota perspective fails these essential tests.

In South Dakota, hospital expenses per admission from 1970-1975 have risen at annual rates ranging from 5 - 13%. During the same period, however, per capita hospital expense expressed as a percentage of per capita income has, in fact, declined from 2.6% to 2.5%.

In addition to the well known and widespread inflationary impact of the general economy on hospital operations,* much of the actual increase in hospital expenses is attributable to the changing nature of

*See Attachments A & B

hospital services in South Dakota. As may be seen on Attachment C, the number of specialized services provided in South Dakota hospitals has increased dramatically over the last 15 years. We are aware of the frequently cited argument that recognizes the increased costs associated with the type of expansion of services illustrated, but rejects the argument that these are valid cost increases in light of "unnecessary" or "duplicative" services. We would submit that that argument in not valid in South Dakota. With a State Certificate of Need Program having been in effect since 1972 and with the widely disbursed geographical location of South Dakota hospitals, we do not believe that this argument can be generalized to the State.

Another factor arguing against a single federal "solution" is the percentage of population over age 65 which varies considerably from state to state. Again, it has been well documented that this segment of the population consumes a disporportionately high share of health and hospital services. In 1976, according to U.S. Bureau of Census figures, 10.7% of the national population was age 65 or older. During the same year, South Dakota's percentage of 65 and over population was 12.5%. Just as the nature of services provided is a unique variable from hospital to hospital and state to state, the population served is a variable which the Administration proposal does not address.

For several years, it has been the formal policy of the State of South Dakota in concert with health provider and consumer groups, to increase the number of physicians in the State. To this end, the University of South Dakota, in Vermillion, now operates a 4 year, degree-granting

Medical School and primary care residency programs are being expanded with both direct and indirect support from state government. We know that as the number of practicing physicians in the State increases, further impact will be made on demand for and the total expenses of hospital services. At this time, in this State, the potential impact of the Administration proposal to subject South Dakota hospitals to a uniform and arbitrary ceiling on revenues, will work at direct cross purposes to a statewide commitment to expand medical services to South Dakota citizens.

Considerable national attention has been given in all areas of the American economy to the impact of government regulations and requirements on cost increases. Nowhere is this impact more evident than among the nation's hospitals. This problem was specifically recognized by a bipartisan interim committee of the South Dakota State Legislature during the summer of 1976. A copy of a resolution adopted by that Committee is included as Attachment D. Note that the Committee states "...WHEREAS, the State of South Dakota is rural and sparsely populated and has a pressing need for wise conservation of manpower resources, which need is not being recognized by Federal regulations; and WHEREAS, most hospitals, nursing homes, and pharmacies in the State are small and are conducting a futile struggle to fulfill the same federal requirements as their counterparts in large metropolitan areas, while simultaneously charged with keeping costs down; and, WHEREAS, there is a need to develop a reasonable, common sense approach to the regulation of health and welfare services in the State of South Dakota; NOW, THEREFORE, BE IT RESOLVED, by the Interim Rules Review Committee of

The South Dakota State Legislature, that the Secretary of Health Education and Welfare be urged to make a comprehensive study of feasible alternatives to the present application of federal Health and Welfare regulations in the State of South Dakota..."

We are in complete accord with the intent of this resolution and believe it has specific applicability to the nature and proposed implementation of the Administration's "Cost Containment Proposal". The message of that legislative committee is simply that there are real and legitimate differences in both the nature of the "problem" of health care costs and the nature of the "solutions" that are or can be applied from one state to the next.

Title I of the Administration proposal, in fact, says very little about containing hospital costs - that is, the cost of goods and services which hospitals must purchase in order to assure the delivery of high quality and increasingly sophisticated and successful health care. Rather, the major part of the proposal establishes a completely artificial limit on hospital revenue. In the absence of constraints on the costs that hospitals inevitably incur and in the presence of legitimate, well-articulated community needs for services, there appear to be three equally unacceptable options available to South Dakota hospitals should the proposal be enacted. First, hospitals could eliminate many of the health and educational services they presently provide to South Dakota communities. Secondly, they could allow the quality of care to deteriorate by hiring fewer skilled personnel or attempting to "make do" with old or obsolete equipment. Third, they could attempt, in the short run,

to consume the assets of the facility in the face of inadequate revenue based on limitations which bear no particular relationship to the legitimate financial requirements of the institution.

A careful review of the proposal indicates the basic inadequacy of the so-called appeals or "exceptions" procedures. The fact that a hospital must be "approaching insolvency" to qualify for exceptions, coupled with the fact that if a hospital receives an exception and is no longer "approaching insolvency" the exception will be removed, reduces the exception process to an absurdity. Additionally, the lack of coordination between Titles I and II produces a situation where a hospital could receive approval for a capital expenditure project and then not be allowed to generate the revenue to support the project.

Title II (Limitation on Capital Expenditures) is especially irresponsible and inappropriate as it would apply to South Dakota. The overall limitation on capital expenditures apportioned on the basis of population, would produce a figure of approximately 7.5 million dollars as an annual ceiling for capital expenditures for South Dakota hospitals Perhaps the most glaring example of the impact of this provision in the State is the fact that a single hospital capital project now underway would have consumed, had the Administration proposal been in effect, some three years worth of the total capital expenditure "allowance" for South Dakota. That project, the construction of a new hospital in Rapid City subsequent to a merger of two existing hospitals, would as we understand the Administration proposal, have precluded any other reviewable capital expenditure by a South Dakota Hospital

for at least the year for which it was approved and quite possibly for some three plus years in all.

Title II contains additional requirements that no new hospital beds may be built in a Health Service Area in which the ratio of beds per thousand population exceeds 4 or in which the average occupancy rate is less than 80%. This would produce throughout the entire State of South Dakota a moratorium on the addition of inpatient beds in any part of the State. Without attempting to comment on the merits or lack of merits of such a proposal on geographically small but densely populated Health Service Areas, we would point out the irrationality of such a provision in a state like South Dakota. To preclude a community hospital 30 or 40 or more miles away from the nearest hospital from responding to legitimate community needs as they may relate to additional inpatient beds because a Health Service Area comprising some 76,000 square miles exceeds a national bed or occupancy formula flies squarely in the face of the demographic realities of the State of South Dakota.

Having outlined our strong objections to the Administration's proposal and its impact on South Dakota, we recognize and accept the responsibility to comment constructively on the issue to which the proposal is addressed.

As we are sure the Subcommittees know, there are a variety of planning and utilization controls already in place which squarely address the issue of hospital costs. The mandate of P.L. 93-641 is being rapidly

implemented in South Dakota as it is throughout the nation. The South Dakota Hospital Association and its member institutions continue to be supportive of reasonable and fairly applied health planning mechanisms. It was, in fact, the South Dakota Hospital Association which initiated the present South Dakota Certificate of Need Law. Additionally, the utilization review and quality assurance activities of the Professional Standards Review Organization program are proceeding rapidly in the State.

While both planning and utilization controls have added considerably to the work load of South Dakota hospitals and have created considerable tension and concern, they differ fundamentally from both major aspects of the present Administration proposal in that, to a significant degree, they operate at the state/areawide level. As such, the programs (while still subject to minimum federal requirements) are able to attune themselves to the realities of and the legitimate need for the delivery of health and hospital services in South Dakota.

We strongly commend this basic model to the Subcommittees as an appropriate one to adopt with reference to the issue of the payment for hospital services. The South Dakota Hospital Association has already initiated a careful but soon to be concluded study of a potential state prospective budget review and approval payment system. For that concept to succeed, and we believe it has much merit, the Federal Government must resist the temptation to react to the hospital cost issue by setting hospital payment levels by unilateral promulgation at the national level. Similarily, for that concept to succeed,

any "cost containment" initiative which is adopted at the federal level must contain a meaningful exception for a state program operating under federal guidelines. Unfortunately, the "state exception" contained in the Administration's proposal is not a legitimate exception because it retains the "9% cap" feature even if an exception is granted. Just as a state certificate of need program and viable health planning under P.L. 93-641 cannot occur under an artifical and arbitrary capital expenditure limitation (in the present case, $7.5 million for South Dakota) adopted without reference to the system to which it is applied, neither can there be a viable state alternative to the hospital payment provisions of the Administration's proposal if legitimate and publicly justifiable levels of hospital payment under such a system cannot exceed a nationally adopted formula (in the present case, a 9% ceiling).

We strongly commend for your consideration, a system of hospital payment review and approval based in concept on those systems in effect in the areas of utilization review/quality assurance and health planning. The cornerstone of that concept is the delegation to the states, under general federal guidelines but without arbitrary caps or ceilings, of the responsibility for regulating hospital payment.

Additionally, we would remind the Subcommittees that there is much work to be done in less politically popular areas for impacting on containing hospital and other health services costs. These include impacting on patient demand through public education and a reexamination of such mechanisms as co-payments and deductibles;

increased emphasis on personal and preventive health care through further work in such areas as substance abuse, nutrition, and environmental illnesses; strengthened fraud and abuse controls in the several governmental payment programs; aggressive cost impact reviews of government regulations of all types; and innovative uses of existing facilities through such programs such as the Social Security Administration's "Reducing Acute Care Costs" Experiment. In all of these efforts, the South Dakota Hospital Association pledges its active support and cooperation.

From the South Dakota perspective, however, we believe that the present Administration proposal meets none of the important tests by which such a proposal must be evaluated. We urge the Subcommittees to reject the proposal and to seriously consider in its place both the existing and proposed approaches outlined in this statement.

Attachment A

COSTS OF SELECTED GOODS & SERVICES PURCHASED BY SOUTH DAKOTA HOSPITALS

ITEM	PERCENT INCREASE 1975-1976
NATURAL GAS	16%
ELECTRICITY	38%
FUEL OIL	11%
MILK	13%
IV SOLUTIONS	33%
SUTURES	14%

SOURCE: SDHA - "COSTS OF SELECTED ITEMS SURVEY"

Attachment B

PROFESSIONAL LIABILITY INSURANCE:
SOUTH DAKOTA HOSPITALS

	1975	1976	% INCREASE (DECREASE)
TOTAL PREMIUMS	$425,549	$918,005	116%
AVERAGE COST PER PATIENT DAY	$.56	$1.21	116%
TOTAL LIMITS OF LIABILITY IN FORCE	$119,900,000	$115,750,000	(3.5%)

Attachment C

SERVICES PROVIDED BY SOUTH DAKOTA HOSPITALS
1960-1975

YEAR	INTENSIVE CARE UNITS	RADIOLOGY* THERAPY DEPTS.	RADIOACTIVE** ISOTOPE SERVICE	RESPIRATORY THERAPY DEPTS.
1960	1	10	6	
1965	6	17	7	
1970	15	17	8	26
1971	13	19	12	21
1972	15	19	12	22
1973	16	16	12	21
1974	18	16	10	23
1975	22	19	15	28

YEAR	BLOOD BANKS	HEMODIALYSIS*** DEPARTMENTS	PHYSICAL THERAPY DEPARTMENTS	SOCIAL WORK DEPARTMENTS
1960	18		14	
1965	17		15	3
1970	27	1	22	6
1971	20	3	20	8
1972	20	4	22	7
1973	22	7	22	7
1974	21	8	21	9
1975	27	7	23	12

* INCLUDES X-RAY, COBALT, & RADIUM THERAPY SERVICES
** INCLUDES DIAGNOSTIC & THERAPUTIC SERVICES
*** INCLUDES INPATIENT & OUTPATIENT SERVICES

SOURCE: AMERICAN HOSPITAL ASSOCIATION GUIDE TO HOSPITALS, 1961, 1966, 1971, 1973, 1974, 1975, 1976.

Attachment D

SOUTH DAKOTA STATE LEGISLATURE

PIERRE, SOUTH DAKOTA

A RESOLUTION, Citing South Dakota's concern for, and the necessity for a detailed study of, alternative methods of applying health and welfare regulations to the state; and urging the Secretary of Health, Education and Welfare to conduct such a study and make a report thereof to the interim Rules Review Committee of the South Dakota State Legislature.

BE IT RESOLVED BY THE INTERIM RULES REVIEW COMMITTEE OF THE SOUTH DAKOTA STATE LEGISLATURE:

WHEREAS, the Committee is charged with reviewing all administrative rules made by state agencies in South Dakota; and

WHEREAS, the state Department of Social Services promulgated 1200 rules in the past year, mostly due to federal mandate; and

WHEREAS, such an excessive volume of rules and their frequent change is causing confusion and having a deleterious effect on the delivery of social services within the state; and

WHEREAS, the state of South Dakota is rural and sparsely populated and has a pressing need for wise conservation of manpower resources, which need is not being recognized by federal regulations; and

WHEREAS, most hospitals, nursing homes and pharmacies in the state are small and are conducting a futile struggle to fulfull the same federal requirements as their counterparts in large metropolitan areas, while being simultaneously charged with keeping costs down; and

WHEREAS, there is a need to develop a reasonable, common-sense approach to the regulation of health and welfare services in the state of South Dakota.

NOW, THEREFORE, BE IT RESOLVED, by the interim Rules Review Committee of the South Dakota State Legislature, that the Secretary of Health, Education and Welfare be urged to make a comprehensive study of feasible alternatives to the present application of federal health and welfare regulations in the state of South Dakota, and to submit a report thereof, and any recommendations resulting therefrom, to the Committee.

BE IT FURTHER RESOLVED, that copies of this resolution be sent to President-Elect Jimmy Carter; United States Senators James Abourezk and George McGovern; Congressmen James Abdnor and Larry Pressler; Dr. Marion J. Philippas, HEW Intergovernmental Affairs Office, Denver; the New Coalition; Legis 50; Governor Richard F. Kneip; and the Committee on Health and Welfare of the South Dakota State Legislature.

Adopted by the interim Rules Review Committee, November 19, 1976.

Dennis C. McFarland

REPRESENTATIVE DENNIS C. MCFARLAND, Chair

Senator Rodney Hall
Senator Curtis Jones
Senator Mary McClure

Representative Beverly Halling
Representative George S. Mickelson

STATE OF SOUTH DAKOTA

RICHARD F. KNEIP
GOVERNOR

EXECUTIVE OFFICE

PIERRE
57501

June 15, 1977

Senator Edward M. Kennedy, Chairman
Subcommittee on Health and Scientific Research
Senate Committee on Human Resources
310 B. Senate Courts Annex
Washington, D.C. 20510

Dear Senator Kennedy:

This will serve as a follow-up to the May 26th letter my Executive Assistant sent to you. I again thank you for inviting me to testify before the Subcommittee at your recent hearings concerning the proposed Hospital Cost Containment Act of 1977. Unfortunately, I was out of the country during your hearings, but I welcome the opportunity to respond to your request at this time. This letter will provide you with my concerns and recommendations regarding this important legislation. I request that if possible, this letter be included in the official record of your hearings.

I make my comments in two capacities. First, as Chairman of the National Governors' Conference Committee on Human Resources, I would like to convey the committee's position on the cost containment issue. Second, as Governor of South Dakota, I would like to relate my concerns regarding the implications of the legislation for South Dakota.

THE POSITION OF THE NATIONAL GOVERNORS' CONFERENCE COMMITTEE ON HUMAN RESOURCES

The members of the Committee on Human Resources have been extremely active in voicing their concerns and recommendations with regard to the inexorable rise in hospital costs. A brief history of our activities follows:

--In July 1976, the Committee established a special task force on Medicaid Reform chaired by Governor George Busbee of Georgia. In its final report, the task force made over twenty specific recommendations for improving the administration, delivery of services and financing of the Medicaid program. These recommendations were unanimously adopted by all the Governors at the N.G.C. meeting in February, 1977. A fundamental conclusion of this report is that the continuous and rapid increase in hospital costs seriously threatens the ability of the states to continue to provide Medicaid services to low income families. Yet, these costs

cannot be contained by focusing on the Medicaid and Medicare programs alone. To be effective, the cost containment efforts must apply to the entire hospital industry. Therefore, the National Governors' Conference called for a new federal initiative to control hospital costs across the nation.

--On February 28, 1977, the Committee on Human Resources met with Health, Education and Welfare Secretary Joseph Califano. Part of the agenda was devoted to the issue of cost containment. Immediately after the meeting, the Committee issued a press release which endorsed the outlines of the cost control proposal and which urged the Congress to act promptly.

--On May 11, 1977, Governor Joseph Garrahy, of Rhode Island, testified on behalf of the National Governors' Conference at the joint hearings sponsored by Congressman Daniel Rostenkowski and Congressman Paul Rogers. Governor Garrahy made the following points:

(1) The Hospital Cost Containment Act of 1977 is a major step toward finding a rational solution to the problems caused by increasing hospital costs.

(2) The cost control program must address all sources of hospital income to have any reasonable chance of succeeding.

(3) The proposal to limit capital expenditures by hospitals is needed to prevent unnecessary hospital expenditures which will further contribute to inflation. However, for the first two years, the Secretary of H.E.W. is required to allocate the funds on the basis of population alone. This requirement does not recognize the differences among the states with regard to capital expenditure needs, especially for modernization and renovation of existing facilities. States with older facilities deteriorate even further in order to program for expenditures allowed under the bill.

(4) The Carter Administration's legislative proposal recognized the acheivements of state government in cost containment programs; future and further experimentation by states should be encouraged and strengthened.

(5) Adequate funds and staff resources need to be available for the administration of this program.

(6) The requirements placed on the newly created Health Systems Agencies may exceed the limits of their present capabilities. The envisioned role for H.S.A.'s may also put them in conflict with state government cost control programs which are run concurrently with the federal program prior to a waiver under Section 117. Therefore, Congress is urged to delegate these responsibilities to state government and to mandate an advisory role for Health Systems Agencies. Please underscore this very important point.

(7) Congress should consider developing a uniform reporting system for hospital financial data. This is needed to provide comparable data from all institutions under the program. A uniform accounting system should not be imposed at this time.

--On May 24, 1977, Governor Michael Dukakis appeared before your subcommittee on behalf of the National Governors' Conference. As you know, he strongly supported the proposed legislation.

As chairman of the Human Resources Committee, I generally agree with the remarks of my two colleagues (although I have several concerns with the specific provisions of the legislation, which are detailed in the next section). A national cost containment program is needed; and it is needed soon. A capital expenditure limit is necessary. As a Nation, we cannot hope to attain fundamental reforms of the health care system without a pause in the present inflationary rate of hospital costs. Yet, cost containment can only be an interim solution at best. We must use the opportunity to implement long-term solutions to the overall problem of financing health care for our citizens.

THE PERSPECTIVE FROM SOUTH DAKOTA

(1) Background: South Dakota is predominately a rural state -- our population of 685,000 is spread out over 76,000 square miles. The state's major problem in health care continues to be the extension of medical services to our citizens. South Dakota has the worst physician-to-population ratio of any state in the Nation. There are 59 acute care hospitals in the entire state, 30 of which have less than 40 beds (only 3 hospitals have over 200 beds, and 6 others have between 100 and 200 beds). Eighteen of the state's 67 counties have no hospitals within their boundaries.

Hospitals in small rural communities are in a very different situation than those in the more metropolitan areas. First, there is a very close relationship between the ability of a community to retain its one or two physicians and the ability of the hospital to remain open. If the hospital closes, the doctor will probably leave the community, because he or she has no institution to send patients. Second, many small hospitals must operate with relatively low occupancy rates (the average occupancy rate in the state is about 50-60 percent, with the larger hospitals tending to show a rate of 80 percent or better, while many smaller institutions experience a sporadic and declining census). Third, in many towns across the state, health care is the first or second sector of the local economy. Thus, if a hospital closes, access to medical services is not only made more difficult, but the community's economy is also seriously harmed.

Hospital costs in South Dakota are inflating at a rate slightly above the national average. Expense per in-patient day increased by 18 percent in 1975 and by 19 percent in 1976. However, the absolute dollar cost for hopsital care is still far less than the national average. In 1976, the cost per in-patient day was $109.77, versus $152.43 for the nation as a whole.

With the above facts in mind, I would now like to discuss the implications of the Hospital Cost Containment Act of 1977 proposal on South Dakota.

(2) Specific Concerns: South Dakota must admit to rising hospital costs. A program of hospital cost containment appears appropriate and South Dakota must agree with the Carter Administration's objectives to: (1) curb inflation; and (2) pave the way for a long range health care cost policy for more than hospitals. The potential problems for South Dakota do not lie with the concept or objectives, but rather with certain features of the proposed legislation, including: (a) The effects that the imposition of a flat nationwide cap of nine percent will have on rural hospitals; (b) the lack of incentives for developing alternatives to institutional care; (c) the implications of the limitations on capital expenditures; (d) the need for providing incentives for states which want to develop their own rate regulation systems; (e) the failure to require uniform reporting systems for hospitals; and (f) the uncertainty over how the program will be implemented. Please allow me to expand on these concerns.

(a) Effects of a flat nine percent cap

I am concerned that the nine percent limit is insensitive and not specific to geographics and needed services in our sparsely populated large state. On a short-term basis of less than a year, the proposal may be tolerable. However, a nine percent lid operating in South Dakota for longer than a year will cause closure of many smaller institutions presently operating on a narrow fiscal margin, thereby excessively decreasing geographic accessibility for South Dakota citizens to hospital services. Second, larger institutions operating with a more comfortable fiscal margin will be forced to delete participation in programs of state-wide and regional importance in health care, e.g., medical education commitments, nursing education programs, other allied health educational programs, perinatal services, specialized child care services, kidney dialysis, chronic disease rehabilitation services, etc. We will then be faced with losing both needed beds and educational and regional services at a time when we are trying to increase the access of South Dakotans to the medical care system.

Another concern is that, even though the cost containment program is geared to slow an excessive inflation rate and be broadly beneficial to consumers of hospital care, its impact in South Dakota in a small community may well be to wipe out the number one or two industry in the community, deprive its citizens of accessibility to services, as well as delete jobs and negatively alter a local economy.

(b) Alternatives to institutional care

The Carter cost proposal does not provide any incentive for the development of alternatives to institutional care. It pushes down, screws the lid on, and contains -- but it contains an existing and unchanged system. We know costs cannot be contained without functional change in the way we now provide care.

In a state where few, if any, alternatives to institutionalization exist and many are needed, it is important to have incentives for the development of alternatives to institutionalization. Alternatives are needed which are designed to change institutional behavior toward outpatient care, home health programs, day care, and other alternatives.

The institutions and hospitals in South Dakota depend upon third party reimbursement for "after illness care" as the mainstay of the health services to their citizens. The financial reimbursement system through Medicare, Medicaid, and the other third party services has contributed to, if not established, the expensive payment for "after illness care". We must also seek to change methods of reimbursement that tie us to a system of after-care. In these areas, the proposal is wholly inadequate.

(c) Limit on capital expenditures

The proposal contains a lid on capital expenditures, which is a valid concept. But if a lid on capital expenditures is established capriciously and not closely tied to appropriate planning mechanisms and a state-wide facility plan, then the capital expenditure lid has little meaning and is only another artificial headache to be administered, implemented, and argued. Moreover, rural states like South Dakota may need much more money than allowed under a formula based on population because we need to expand facilities in key services which are wholly lacking in the entire state.

(d) State rate regulation programs

The proposal gives due credit to States which now have systems of rate regulation. However, there must be incentives to other states to develop their own rate regulation systems. The establishment of effective systems by states would benefit everyone -- it would allow states to deal with their unique problems and it would allow the federal government to set appropriate national policy without imposing stringent requirements that do not meet the needs and problems of rural areas.

(e) Uniform reporting

The proposal fails to address uniformity in reporting and development and creation of a valid data base on which to predict, and base future decisions.

(f) Implementation

With so many unknowns, South Dakota is gravely concerned about how implementation will occur. Will the responsible bureaucracy allow true State implementation? Will appropriate funding be provided to those who implement it? Will the regulations slip into the usual mold of creating costs and impossible headaches for state government and the institutions through vacillating inappropriate thought and management at a regional or central level?

RECOMMENDATIONS

The usual temptation after reciting a list of problems is to stop and leave it to the Members of Congress to develop alternatives. However, I would like to offer several recommendations for the subcommittee's consideration.

(1) Whatever limit on hospital income is established, the Act should be amended to specify an explicit period for the limit to be in effect. By including this provision, all parties would know how long we have to live with this interim measure. It would further spur the Administration and Congress to develop long-term reforms as quickly as possible. All too often, "interim" measures either become permanent or are ended with no reforms to take their place.

(2) Congress must develop a program which does not exacerbate the service delivery problems of rural states like South Dakota which do not have the tremendous problems of duplication of services and facilities, over-supply of beds and extremely high absolute hospital costs. A program designed only to solve the problems of metropolitan states will not work in our state. South Dakota with its scarce resources being utilized to extend health care services to its population, could not support a program which negates our efforts by decreasing services and closing rural hospitals.

(3) A formula for capital expenditures should be designed which immediately recognizes factors other than population. A suggested methodology would be to utilize a formula which takes into account "medically underserved areas" for capital expenditures, much like the federal government utilizes for its health manpower programs.

Another factor which needs to be considered is the need for appropriate regional and statewide specialized services. In contrast to many other states, South Dakota does not have a university-based system which provides regional speciality services. Rather, state government stimulates the private sector to develop these services. For example, we have a hospital in the state that is being asked to expand its high-risk mother and infant facilities. The expansion in this one hospital would increase services to the entire state's population, and would cost approximately $5 million. Yet our entire state's allocation under the formula contained in the proposed bill would be $2.5 million.

Again, this is a case in which areas which are already experiencing problems with inadequate services would be harmed by the Administration's proposal.

(4) Incentives should be included in the legislation to encourage alternatives to institutionalization. I am in agreement with your statement of April 25th in which you said: "Incentives must simultaneously be built to

encourage use of ambulatory care facilities, outpatient departments, appropriate long-term care facilities and home health agencies. We must insure that no one in need of care is denied care because of present limitations in the reimbursement system."

(5) While the Administration's proposal allows states which already have rate-setting programs in place to retain these programs, I believe that other states should be given a greater opportunity to establish their own systems than is presently envisioned in the bill. Many states are in various stages of developing their own systems, and they should be given a greater chance to implement their own program.

Let us remember that it has taken the state programs which now work well, at least three years to achieve their success. For example, although Johns Hopkins Hospital will achieve the nine percent goal this year, it was unable to do so the first two years of Maryland's program. Can we expect a great deal more from less sophisticated hospitals and programs?

(6) The implementation of the program will be critical to its success. Based on past experience with federal programs, I strongly urge Congress to include a provision which directs the Department of Health, Education and Welfare to prepare regulations by a certain date, to make the regulations short and to write only those which are absolutely necessary. In the past, problems relating to regulations have often delayed, complicated and confused the administration of programs to the point of absurdity. We cannot afford to permit such a situation to occur in this program.

Another recommendation is that adequate funding must be included to provide for the staff and resources required to implement the program.

(7) A uniform reporting system should be included in the legislation.

(Continued)

I hope my comments will prove useful to you. I wish you and the subcommittee the very best in your deliberations on this matter. If I can be of any further assistance, do not hesitate to communicate with me. With best wishes, I remain

Sincerely,

GOVERNOR RICHARD F. KNEIP, CHAIRMAN
N.G.C. COMMITTEE ON HUMAN RESOURCES

RFK: crd

cc: Senator George McGovern
Senator James Abourezk
Senator Herman Talmadge
Congressman James Abdnor
Congressman Larry Pressler
Congressman Paul Rogers
Congressman Daniel Rostenkowski
Governor George Busbee
Governor Richard Lamm
Miss Judith K. Call, Secretary
Department of Health

STATE OF SOUTH DAKOTA

RICHARD F. KNEIP
GOVERNOR

EXECUTIVE OFFICE

PIERRE
57501

May 26, 1977

Senator Edward M. Kennedy, Chairman
Subcommittee on Health & Scientific Research
Senate Committee on Human Resources
310B Senate Courts Annex
Washington, D.C. 20510

Dear Senator Kennedy:

This letter will serve to acknowledge the recent telephone call which I received from Dr. Shapiro of your staff. Governor Kneip is currently in the country of Japan on a two-week U.S. Department of State/National Governors' Conference tour of that country. Thus the reason for my interim reply on the matter of the proposed Hospital Cost Containment Act of 1977.

I have enclosed three documents for your information. The first is a copy of the statement released by the National Governors' Conference Committee on Human Resources on February 28th. This statement endorsed the concept of an industry-wide cap on hospital cost increases.

The second document is Governor Kneip's News Release of April 26th wherein he expressed his general support for the Administration's proposal as announced on April 25th.

The third is a copy of the testimony of Rhode Island Governor Joseph Garrahy before two House of Representatives subcommittees on May 11th. Governor Garrahy is the lead Governor in health policy for the N.G.C. Committee on Human Resources, and he testified in support of the Administration's proposal.

I hope that these enclosures are useful to you. Governor Kneip has asked his Secretary of Health to analyze the implications for South Dakota of the specific components of the proposal. This analysis will be ready for the Governor to review when he returns to the state. At that time, he will send you a more specific reply outlining his concerns and recommendations.

I wish you the very best in your deliberations and in behalf of Governor Kneip I thank you for soliciting his thoughts on this matter. I remain

Sincerely,

Daniel B. Garry

DANIEL B. GARRY
EXECUTIVE ASSISTANT

DBG:ldg
cc: Governor Richard F. Kneip
The Honorable George McGovern
The Honorable James Abourezk

Statement released by the Committee on Human Resources of the National Governors' Conference
February 28, 1977

STATEMENT ON HOSPITAL COST CONTROL

The National Governors' Conference Committee on Human Resources, chaired by Governor Richard F. Kneip of South Dakota, met today with HEW Secretary Joseph A. Califano, Jr. to discuss a number of issues of concern to the Governors. Among the items of discussion was the need for prompt action to control health cost increases. At the close of the meeting Governor Kneip issued the following statement.

"This morning the National Governors' Conference adopted a major new policy position on Medicaid reform which calls for a new federal initiative to control the rapidly escalating costs of health care. Hospital costs are a critical part of these cost increases which threaten the ability of the States to continue to provide badly needed health care for low income families. The National Governors' Conference is convinced that these costs cannnot be controlled within the Medicaid and Medicare programs alone. Industry wide limits are needed and they must apply across the whole nation.

"The Human Resources Committee is pleased that the President and Secretary Califano also recognize this need and we are encouraged by their proposal for an industry-wide cap on hospital cost increases as was outlined in President Carter's budget revisions presented last week.

"While the development of the details of an effective cost control mechanism will require time and detailed consultation and cooperation with state and local governments as well as with health care providers and insurers, we believe that such a mechanism is necessary. The

Committee commends the President and Secretary Califano for their proposal and we urge Congress to act promptly to provide the necessary legal authority for cost control measures.

"Secretary Califano has indicated that the States will be fully involved in the development and implementation of these cost control measures and we look forward to working closely with HEW in this important project.

"Many States have already taken significant steps to control health costs. We fully expect to continue to play a major role. As a result Federal/State cooperation in this area is vital."

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The members of the Human Resources Committee are:

Governor Richard F. Kneip, South Dakota - Chairman
Governor Michael S. Dukakis, Massachusetts
Governor Cliff Finch, Mississippi
Governor Jerry Apodaca, New Mexico
Governor Hugh L. Carey, New York
Governor David L. Boren, Oklahoma
Governor J. Joseph Garrahy, Rhode Island
Governor John Evans, Idaho
Governor Reubin O'D. Askew, Florida - ex officio

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The Medicaid policy positions adopted by the National Governors' Conference were based on the work of the Medicaid Task Force chaired by Governor George Busbee of Georgia.

EXECUTIVE OFFICE
STATE CAPITOL
PIERRE, SOUTH DAKOTA 57501

FOR RELEASE TUESDAY, APRIL 26, 1977

GOVERNOR RICHARD F. KNEIP, OF SOUTH DAKOTA, AND CHAIRMAN OF THE HUMAN RESOURCES COMMITTEE OF THE NATIONAL GOVERNORS' CONFERENCE TODAY VOICED SUPPORT FOR THE CONCEPT EMBODIED IN PRESIDENT JIMMY CARTER'S HOSPITAL COST CONTAINMENT PROPOSAL.

THE NEW ADMINISTRATION'S PROPOSAL WAS UNVEILED YESTERDAY BY THE PRESIDENT AND HEALTH, EDUCATION AND WELFARE SECRETARY, JOSEPH CALIFANO. THE GOVERNOR SAID, "THE COST OF HOSPITAL CARE IN THIS COUNTRY HAS BEEN INCREASING AT A RATE OF FIFTEEN PERCENT PER YEAR. THE COST OF SECURING THIS TYPE OF HEALTH CARE MUST, THEREFORE, BE OF CONCERN TO ALL OF US, IF WE ARE TO AVERT SEEING THE TIME WHEN VITAL MEDICAL SERVICES ARE UNAFFORDABLE TO THE AVERAGE CITIZEN OF AMERICA."

KNEIP SAID, "I REALIZE HOSPITAL CARE IS ONLY ONE ASPECT OF THE NATION'S HEALTH CARE DELIVERY SYSTEM -- BUT A VERY IMPORTANT ONE. IN ADDITION TO FOCUSING ATTENTION ON THE INCREASING COSTS OF HOSPITAL CARE, THE CARTER PROPOSAL WILL FORCE US TO EXAMINE THE REASONS FOR THE INCREASES."

GOVERNOR KNEIP POINTED OUT THAT STATE PROGRAMS DESIGNED TO PURCHASE MEDICAL SERVICES FOR THE POOR ARE NOW COSTING MORE THAN PROGRAMS DESIGNED TO HOUSE, FEED AND CLOTHE THEM. THE GOVERNOR SAID, "I APPLAUD THE PRESIDENT FOR HIS BOLD INITIATIVE IN THIS AREA

AND I LOOK FORWARD TO WORKING WITH HIS ADMINISTRATION ON THE DRAFTING AND IMPLEMENTATION OF AN APPROPRIATE STATUTE."

KNEIP EXPRESSED PLEASURE WITH THE ADMINISTRATION'S ATTEMPT TO ACCOMMODATE COST CONTAINMENT INITIATIVES BY STATE GOVERNMENT. THE CARTER PROPOSAL WOULD EXEMPT HOSPITALS IN STATES WITH RATE REGULATION PROGRAMS FROM COVERAGE BY THE FEDERAL STATUTE. OTHER STATES COULD BEGIN SEPARATE HOSPITAL COST CONTAINMENT PROGRAMS UNDER FEDERAL AUTHORITY OF THE SOCIAL SECURITY AMENDMENTS OF 1972. THE GOVERNOR SAID, "REGULATORY PROGRAMS SUCH AS THE ONE PROPOSED BY PRESIDENT CARTER ARE OFTEN MORE EFFECTIVE WHEN THEY ARE CLOSELY ATTUNED TO THE UNIQUE CHARACTERISTICS OF THE HEALTH SYSTEM WITHIN A STATE AND I AM PLEASED THAT THIS OPTION REMAINS OPEN."

HE WENT ON TO SAY THAT IF STATE AND FEDERAL GOVERNMENT LEADERS AND POLITICIANS ARE SINCERE ABOUT A HOSPITAL COST CONTAINMENT PLAN, THEY MUST ALSO BE WILLING TO PUT A "CAP" ON THE EXPENSES TO HOSPITALS WHICH ARE MANDATED BY FEDERAL LEGISLATIVE REQUIREMENTS.

KNEIP CONCLUDED BY SAYING, "I INTEND TO WORK WITH SECRETARY CALIFANO ON DRAFTING AND IMPLEMENTING THIS PROPOSAL. I KNOW MANY QUESTIONS REMAIN TO BE ANSWERED AS THE PROPOSAL WORKS ITS WAY THROUGH CONGRESS; BUT I AM PLEASED THAT THE PRESIDENT AND HIS H.E.W. SECRETARY HAVE PLEDGED TO GIVE GOVERNORS INPUT INTO THE IMPLEMENTATION OF THIS PLAN."

TESTIMONY OF J. JOSEPH GARRAHY

GOVERNOR OF RHODE ISLAND

ON BEHALF OF

THE NATIONAL GOVERNORS' CONFERENCE

BEFORE THE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

AND

SUBCOMMITTEE ON HEALTH

COMMITTEE ON WAYS AND MEANS

WASHINGTON, D.C.

MAY 11, 1977

MISTERS CHAIRMAN, HONORABLE MEMBERS OF THESE COMMITTEES, BARELY THREE WEEKS HAVE PASSED SINCE I HAD THE PRIVILEGE OF REPRESENTING THE NATIONAL GOVERNOR'S CONFERENCE TO ADDRESS MEMBERS OF THE HOUSE SUBCOMMITTEE ON LONG-TERM CARE ABOUT THE RISING COSTS OF MEDICAID AND THE NEED FOR BASIC REFORM.

I AM PLEASED TO COME BEFORE YOU TODAY TO SPEAK ABOUT A RELATED ISSUE, AN ISSUE THAT STRIKES AT THE HEART OF THE COSTS OF HEALTH CARE IN AMERICA - THE ISSUE OF HOSPITAL COST CONTAINMENT.

I KNOW THIS TO BE A MATTER OF GREAT CONCERN TO BOTH CHAIRMAN ROGERS AND CHAIRMAN ROSTENKOWSKI AND I COMMEND YOUR

COLLECTIVE EFFORTS TOWARD IMPROVING THE EFFECTIVENESS AND EFFICIENCY OF OUR HEALTH CARE DELIVERY SYSTEM. THE PROBLEMS OF COSTS, I KNOW, HAVE BEEN ON YOUR MINDS FOR SOME TIME AND I CAN ASSURE YOU IT IS A PRIORITY WITH THE NATIONS' GOVERNORS.

I CONGRATULATE PRESIDENT CARTER'S INITIATIVES THROUGH HIS COMPREHENSIVE PROPOSAL AND I AM PLEASED TO APPEAR TODAY TO OFFER MY SUPPORT AND THAT OF MY FELLOW GOVERNORS FOR THE CONCEPTS CONTAINED IN THE ADMINISTRATION PROPOSAL.

MEDICAL CARE EXPENDITURES IN THE UNITED STATES ARE ESTIMATED TO ABSORB ALMOST 9% OF THE GROSS NATIONAL PRODUCT. NEARLY ONE-THIRD OF EVERY DOLLAR SPENT THROUGH STATE MEDICAID PROGRAMS IS SPENT FOR IN-PATIENT HOSPITAL CARE. THROUGH THE

FIRST TWO QUARTERS OF FISCAL YEAR 1976, MEDICAID EXPENDITURES ON IN-PATIENT HOSPTIAL CARE WERE GROWING AT THE RATE OF 20% OVER THE COMPARABLE PERIOD OF THE PREVIOUS YEAR. AT THE SAME TIME, WHILE THE NUMBER OF PUBLIC ASSISTANCE RECIPIENTS INCREASED BY ABOUT 5% - AND UTILIZATION OF MEDICAL CARE SERVICES WAS DECLINING BY ABOUT 5% - THE COST PER UNIT OF SERVICE PURCHASED BY THE PROGRAM HAD INCREASED BY 22%. TO QUOTE CHAIRMAN ROGERS IN HIS FLOOR SPEECH ON APRIL 25TH ALL OF US WHO HAVE TO DEAL WITH THE DIFFICULT ISSUES OF ALLOCATING SCARCE DOLLARS TO AN ENDLESS NUMBER OF PRESSING DEMANDS TO IMPROVE ACCESS TO AND THE AVAILABILITY OF HIGH QUALITY HEALTH CARE SERVICES . . . . KNOW THE FRUSTRATION OF SEEING OUR HEALTH CARE DOLLARS EATEN UP BY THE INCREASES IN COSTS WHICH FAR EXCEED THE GENERAL INCREASES

IN THE COSTS OF LIVING."

MR. CHAIRMEN WE COME TODAY TO ECHO THAT FRUSTRATION AND TO OFFER OUR COMMON EFFORTS TOWARD A RATIONAL SOLUTION. THE HOSPITAL COST CONTAINMENT ACT OF 1977 IS A MAJOR STEP IN THAT DIRECTION.

IF I MAY, I WOULD TAKE A MOMENT TO DISCUSS POINTS ABOUT WHICH WE SHARE AGREEMENT WITH THE ADMINISTRATION PROPOSAL.

I AGREE WITH PRESIDENT CARTER THAT A PROGRAM MUST ADDRESS ALL SOURCES OF HOSPITAL INCOME TO HAVE ANY REASONABLE CHANCES OF SUCCESS. MANY OF MY COLLEAGUES IN THE NATIONAL GOVERNOR'S CONFERENCE HAVE HAD THE EXPERIENCE OF CONTROLLING MEDICAID EXPENDITURES OR BLUE CROSS REIMBURSEMENTS ONLY TO FIND TOTAL

MEDICAL CARE COSTS RISE AT THE SAME, OR AT AN ACCELERATED RATE ALL AT THE EXPENSE OF THE OTHER PURCHASERS OF CARE. EVEN WORSE PARTIAL CONTROLS PROVIDE AN INCENTIVE TO DISCRIMINATE AMONG PATIENTS ON THE BASIS OF THEIR THIRD-PARTY COVERAGE RATHER THAN ON THEIR NEED FOR MEDICAL CARE.

I FIND MYSELF IN AGREEMENT WITH THE ADMINISTRATION'S PROPOSAL TO LIMIT CAPITAL EXPENDITURES BY HOSPITALS. THE PREVENTION OF UNNECESSARY CAPITAL EXPENDITURES WHICH WILL FUEL INFLATION IS AN ENDEAVOR WHICH WILL HAVE THE ACTIVE SUPPORT OF MOST PARTICIPANTS IN THE HEALTH CARE MARKET.

I AM PLEASED THAT THE PRESIDENT'S PLAN RECOGNIZES THE ACHIEVEMENTS OF STATE GOVERNMENT IN COST CONTAINMENT PROGRAMS. MANY OF US WHO HAVE BEEN TRYING TO REGULATE HEALTH CARE COSTS REALIZE THAT WE ARE IN UNCHARTERED WATERS. I URGE YOUR SUPPORT

FOR THOSE PARTS OF THE LEGISLATION WHICH ENCOURAGE FUTURE AND FURTHER EXPERIMENTATION BY INDIVIDUAL STATES.

HISTORICALLY, STATE GOVERNMENT HAS BEEN INVOLVED IN HEALTH COST CONTAINMENT THROUGH THE REGULATION OF INSURANCE COMPANIES DOING BUSINESS IN THE STATE. IN THE 1930'S MEDICAL SERVICE CORPORATIONS - BLUE CROSS PLANS - WERE ORGANIZED THROUGHOUT THE UNITED STATES. IN MOST STATES, STATUTES GAVE AN APPROPRIATE STATE OFFICIAL THE POWER TO APPROVE ANY CHANGES IN THE PREMIUMS CHARGED BY THESE CORPORATIONS TO THEIR SUBSCRIBERS.

WITH THE ADVENT OF THE MEDICAID PROGRAM IN 1965, STATE GOVERNMENT BECAME A MAJOR PURCHASER OF HEALTH CARE. IN THIS ROLE, STATE GOVERNMENT BECAME A MORE DIRECT PARTICIPANT IN THE REGULATION OF HEALTH CARE PRICES.

More recently, some States have enacted statutes which require State approval of the rates paid for medical care services by a variety of third-party payors. The Federal government has supported experiments of this nature under authority granted under both the Social Security Act and the Public Health Service Act.

As you can see, the State shares your interest in hospital cost containment. In Rhode Island we were able to limit our rate of growth to 10.5% last year, almost 5% under the national rate. Soon we will announce an agreement with Rhode Island hospitals which will be at a figure even lower than our most recent sucess.

A number of States, including my own, are considering cost containment and rate regulation incentives at the present time.

It is pleasing to note the interest shown in these initiatives by the Administration proposal and I urge you to consider these same initiatives as you debate the proposal.

While I strongly endorse the concept of hospital cost containment there are specific elements of the plan that merit serious consideration by the committee.

First, I think we can avoid speaking of the limits imposed under this program as a "ceiling" on total hospital revenues. The percentage figure to be promulgated by the Secretary of Health, Education and Welfare by October 1 each year will be the basic increase in revenues which every hospital will receive. Many hospitals will legally increase their revenues well beyond the national figure. The major sources of such an increase

ARE THE FOLLOWING:

- IF THE PERCENTAGE INCREASE IN WAGES FOR NON-SUPERVISORY EMPLOYEES IN A HOSPITAL EXCEEDS THE NATIONAL LIMIT ON HOSPITAL REVENUES, THAT PORTION OF A HOSPITAL'S BUDGET WILL NOT BE SUBJECT TO THE NATIONAL LIMIT.

- INCREASES IN ADMISSIONS TO A HOSPITAL OF BETWEEN TWO AND FIFTEEN PERCENT WILL RESULT IN AN INCREASE IN TOTAL REVENUES OF AS MUCH AS 6.5 PER CENT IN ADDITION TO THE AMOUNT ALLOWED UNDER THE NATIONAL LIMIT.

THERE ARE ARGUMENTS FOR AND AGAINST EACH OF THESE EXCEPTIONS AND I AM SURE YOU WILL HEAR THEM. THE POINT I WOULD LIKE TO MAKE IS THAT THIS PROCESS IS AN EXPERIMENT IN CONTAINING THE INCREASES IN HOSPITAL COSTS. WE SHOULD NOT BE BUILDING FLOORS OR CEILINGS AND WE SHOULD NOT LEAVE THE IMPRESSION THAT

THAT'S WHAT WE'RE TRYING TO DO.

SECOND, THE COMMITTEES SHOULD ASSURE THEMSELVES THAT ADEQUATE FUNDS AND STAFF RESOURCES ARE AVAILABLE FOR THE ADMINISTRATION OF THE PRESIDENT'S PROPOSAL. WE LEARN FROM STATES WHICH HAVE EXPERIENCE IN RATE REGULATION THAT PERSONNEL WITH SPECIALIZED SKILLS AND A SIGNIFICANT AMOUNT OF FUNDS ARE NECESSARY TO GET THIS KIND OF SYSTEM UP AND RUNNING. WITH ONLY MODERATE SUCCESS, THE COSTS OF THE REGULATORY PROCESS WILL BE MORE THAN OFFSET BY THE SAVINGS IN MEDICAL CARE EXPENDITURES IN A RELATIVELY SHORT PERIOD OF TIME. IT WILL NOT FUNCTION AT ALL, HOWEVER, UNLESS WE MAKE SOME FAIRLY EXPLICIT PLANS TO START IT UP.

THIRD, CAREFUL ATTENTION SHOULD BE GIVEN TO THE ABILITY OF THE NEWLY-CREATED HEALTH SYSTEMS AGENCIES AROUND THE NATION

TO CARRY OUT THE RESPONSIBILITIES WHICH THE BILL WOULD THRUST UPON THEM. JUST ABOUT THE TIME THESE AGENCIES GET THEIR HEADS ABOVE WATER, THIS LEGISLATION WOULD REQUIRE THEM TO TAKE A FAIRLY ACTIVE ROLE IN THE REGULATION OF THE MAJOR PROVIDERS IN THEIR HEALTH SERVICE AREA. IT MAY BE THE "LAST STRAW" FOR SOME STRUGGLING AGENCIES AND IT MAY THROW THE BEST OF THEM INTO CONFLICT WITH STATE GOVERNMENT COST CONTAINMENT PROGRAMS WHICH ARE RUN CONCURRENTLY WITH THE FEDERAL PROGRAM PRIOR TO A REQUEST FOR A WAIVER UNDER SECTION 117. IN ANY CASE, I WOULD ASK YOU TO CONSIDER DELEGATING THESE RESPONSIBILITIES TO STATE GOVERNMENT WHILE MANDATING AN ADVISORY ROLE FOR HEATH SYSTEMS AGENCIES. (THIS MAKES ESPECIALLY GOOD SENSE IN SEVERAL STATES -- INCLUDING RHODE ISLAND -- WHICH HAVE NO HEALTH SYSTEMS AGENCIES.)

FOURTH, I WOULD URGE YOU TO GIVE SOME ATTENTION TO THE DEVELOPMENT OF A UNIFORM REPORTING SYSTEM FOR HOSPITAL FINANCIAL

DATA. WITHOUT COMPARABLE DATA FROM ALL INSTITUTIONS COVERED BY THIS PROGRAM, WE'LL NEVER KNOW WHETHER WE SUCCEEDED OR - WHY WE FAILED. I WOULD NOT URGE THE IMPOSITION OF THE SAME CHART OF ACCOUNTS ON EVERY HOSPITAL AT THIS TIME. RATHER I HAVE IN MIND THE DEVELOPMENT OF A "MINIMUM BASIC DATA SET," SIMILAR TO THOSE CREATED UNDER THE COOPERATIVE HEALTH STATISTICS SYSTEM FOR OTHER FACETS OF THE HEALTH CARE SYSTEM.

FINALLY, I AM CONCERNED ABOUT THE ALLOCATION OF THE NATIONAL CAPITAL EXPENDITURE LIMIT TO THE STATES FOR THE FIRST TWO FISCAL YEARS OF THE PROGRAM'S OPERATION. FOR THOSE TWO YEARS, THE SECRETARY IS REQUIRED TO ALLOCATE THE LIMIT ON THE BASIS OF POPULATION ALONE. THE BILL ALSO REQUIRES THE STATE

CAPITAL EXPENDITURE REVIEW PROGRAM TO ACCOUNT FOR THE PRIORITIES WITHIN THE STATE FOR MODERNIZATION AND RENOVATION OF EXISTING FACILITIES. THE NEED FOR MODERNIZATION AND RENOVATION, I WOULD SUGGEST, HAS A TENUOUS RELATIONSHIP TO POPULATION; THIS NEED IS DIRECTLY RELATED TO THE AGE OF THE PHYSICAL PLANT IN EACH STATE'S HEALTH CARE SYSTEM. STATES WITH OLDER PHYSICAL PLANTS MAY FIND THEMSELVES FORCED TO LET THOSE FACILITIES DETERIORATE EVEN FURTHER IN ORDER TO PROGRAM THE CAPITAL EXPENDITURES ALLOWED UNDER THE BILL. THE BILL DOES NOT RECOGNIZE DIFFERENCES AMONG STATES UNTIL FISCAL YEARS BEGINNING 18 MONTHS AFTER ENACTMENT; I WOULD ENCOURAGE YOU TO CONSIDER THE PROBLEM OF AGING PHYSICAL PLANTS AND THE POSSIBILITY OF MOVING UP THE TIMETABLE FOR ADJUSTING THE CAPITAL EXPENDITURE FORMULA.

As I said Mister Chairman we come here today to offer our common efforts toward a solution. We need a national cost containment program which will represent the best collective effort of all levels of government. I believe the Administration's proposal can succeed. We must not oversell it - we must work together to implement it.

I am confident that, given an active role in the plans, States and her governors will give their strongest support and their effective involvement in implementing this legislation.

Thank You.

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THA
TEXAS HOSPITAL ASSOCIATION 6225 U.S. Highway 290 East — Mailing Address: P.O. Box 15587, Austin, Texas 78761 — A.C. 512-453-7204

June 8, 1977

Mr. Stuart Shapiro
United States Senate Human Resources
Subcommittee on Health
4228 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Mr. Shapiro:

On behalf of the more than 600 institutional members of the Texas Hospital Association, we would like to submit to the Human Resources Health Subcommittee testimony in opposition to S. 1391, the proposed Hospital Cost Containment Act of 1977. Enclosed are five (5) copies of testimony that was also submitted to the joint hearings of the Health Subcommittees of the House Committee on Ways and Means and the House Committee on Interstate and Foreign Commerce.

Of particular interest is our recommendation to recognize voluntary cost containment efforts and to encourage state and metropolitan hospital associations to enlarge their role in increasing hospital productivity.

As always, we stand ready to provide any information or assistance you may desire.

Sincerely,

O. Ray Hurst, CAE
President

ORH/afb/kf

TESTIMONY OF THE TEXAS HOSPITAL ASSOCIATION
TO THE HEALTH SUBCOMMITTEES OF THE SENATE HUMAN RESOURCES COMMITTEE

REGARDING H.R.6575, THE HOSPITAL COST CONTAINMENT ACT OF 1977

On behalf of the 670 institutional members of the Texas Hospital Association the following comments are offered in consideration of H.R. 6575 and S. 1391 -- The Hospital Cost Control Act of 1977.

GENERAL COMMENTS

The Texas Hospital Association together with the rest of the institutional health care provider industry recognizes the phenomenon of rapidly rising costs related to the health services delivered within the hospitals of the nation.

The Texas Hospital Association stands ready to support, as evidenced by its own performance that will be discussed later, reasonable programs designed to provide today's level of health care at prices that reflect the efficient use of resources. On the other hand, the Texas Hospital Association unalterably opposes the imposition of limitations on the permissable revenue increases of hospitals as a reasonable and workable method of "cost control."

Socioeconomic factors that are well known to us all have catapulted the health care industry into the active political arena. Involvement in this arena has resulted in a continuous and increasing questioning of government and hospital leadership about which of the older policies of management are now outmoded. In this environment, hospital leadership and governments are facing serious problems in credibility, evolving regulatory mechanisms and cost containment.

Governments, especially the federal government, have responded by the formation of new agencies or sub-agencies and by taking quantum jumps in the number of regulatory schemes, each more costly than the other. Hospitals have responded in many ways, including demonstration of reluctance to disclose information that they suspect may be lifted out of context and misinterpreted. The net result of these

actions and reactions is an increase in the credibility gap between the public and both hospitals and governments.

The spate of governmental restrictions which were designed as remedial action has merely increased the negative images of both hospitals and the governmental systems that have assumed interventionist, if not operational roles. Basic to this problem is cost containment, but perhaps even more critical is the need for elimination or reduction of the current credibility gap.

Specifically, the hospital field is prepared to cooperate with government, but the proposals enunciated in H.R. 6575 are so impractical (unless complete governmental assumption is the goal) that cooperation is ruled out. H.B. 6575 is merely a thinly disguised reconstitution of the ill-fated phase IV wage price controls of yester year, which the Congress killed.

I shall not dwell on the overall unfairness and illegality of imposing caps on one industry while others remain uncontrolled -- this is certain to be covered by others.

However, among the other glaring deficiencies of the proposal are these:
-Proposal plainly punishes hospitals that have attempted and succeeded in containing costs and fails to establish any criteria for the less efficient.
-Desperation of the bill is evident when a rule of thumb of 4 beds per 1,000 is established -- this is a rule that has proven to be meaningless based on the last 25 years experience.
-In press releases, HEW states that controls are simple, require no new data collection, and can be handled by current bureaucracy. (Page 5 of press release HEW dated 4/25/77.) Either current bureaucracies are grossly over staffed, or these statements are meaningless as the proposal speaks of investigation of changing patient loads (something that hasn't been measured in terms of costs to date),

maintenance of charity loads, and changing of hospital functions. These, among other proposed controls and investigations, have not been accomplished even in theory, let alone in practice to date. To suggest that this can be done without additional costs to hospitals plus an inflationary increase of governmental employees, reflects the lack of thought given to the entire proposed law.

Perhaps the most glaring "power grab" is that the proposal entirely ignores the voluntary sector and proposes increased governmental bureaucracies both at the federal and state levels. It thus fails to utilize existing non-governmental agencies that are already in place but ignored in the proposal.

Why should not efforts to contain costs provide for the voluntary system to compete with governmental system -- after all, governmental control systems have not worked well in the past.

What is needed is an immediate positive result with the quantifiable demonstrable promise of further improvements. A lengthly listing of dubious accomplishments, bright promises of future research findings and governmental actions are doubtful value. I maintain that an accountable image and financial stability are possible now using already developed research findings that are currently translatable into operational realities -- all this without the formation of new governmental agencies and/or the creation of additional administrative controls. The framework for this now exists and is in a form that will furnish media for accountability to our constituents. The foregoing, as will be seen, is not a plea for the status quo -- far from it.

I would like to propose that government encourage massive infusion of those managerial practices that have proven to be successful when true cooperation between government and the private sector has been attained unfettered by bickering between differing governmental agencies. Let me enlarge on this idea.

Texas hospitals have long been aware of escalating health care costs. Their favorable reaction is indicated by the fact that Texas hospitals' costs consistently have been below national averages. Cost per hospital case is currently 20 percent higher nationally than in Texas. In spite of this accomplishment there is an increased and continuing willingness of enlightened aggresive hospital leadership to re-examine business concepts, methodologies, and accountability with a view of adoption and/or adaption to the hospital field.

In 1975, the Texas Hospital Association created, in conjunction with the Department of Health, Education, and Welfare, the Statewide Hospital Productivity Center with the goal to expedite the implementation of accepted cost saving managerial techniques. After 18 months of operation over one-third of all Texas hospitals are participating in at least one of the programs. Already substantial cost savings can be demonstrated to communities, consumers, patients, hospitals and third party payors. The savings or cost reductions reported here are those that will withstand the most rigorous financial audit on a "before and after basis." These represent direct, measurable savings, and are conservative.

Recommendation

As previously mentioned the establishment of additional governmental agencies and the multiplying of regulatory programs have not proven to be effective, but to the contrary have been recognized by the majority as cost increasing measures. Why not use already established governmental and hospital structures?

IT IS THEREFORE RECOMMENDED THAT STATE AND METROPOLITAN HOSPITAL ASSOCIATIONS BE ENCOURAGED TO ENLARGE THEIR ROLE IN INCREASING HOSPITAL PRODUCTIVITY BY MEANS OF MATCHING FUNDS CONTRACTS CONTAINING PERFORMANCE CLAUSES.

This plan would not require any changes, either at the governmental level or in the hospital structure. The hospital sector is ready, as evidenced both by our results and the spread of this action by accretion to the neighboring states. This would require governmental inter-agency cooperation, or at lease, recognition, but this is possible as evidenced by the operation of the Texas Statewide Hospital Productivity Center and its results. Strong executive leadership is, required however, as massive infusion is much more difficult and politically tricky than research. However, under this program results are rapid and immediately visible.

In conclusion, it is respectfully requested that serious immediate attention be given to our recommendation. We know full well that this will require statesmanship of the highest order by governmental leadership, but the same high type of leadership will also be required by the hospital industry, and our risk is also great. But we in the hospital industry are ready as demonstrated.

5/18/77 mp

UCHS

To: Members of the U.S. Senate Committee on Human Resources
Members of the U.S. Senate Committee on Finance
Members of the U.S. House Committee on Ways and Means
Members of the U.S. House Committee on Interstate and Foreign Commerce
Senator Clifford P. Case
Senator Harrison A. Williams, Jr.
New Jersey Congressional Delegation
Union County's State Legislative Delegation
Union County Board of Chosen Freeholders
City Council of Elizabeth
Administrators of the Union County Hospital Society
Elizabeth General Hospital, Board of Trustees
Jack W. Owen, President, New Jersey Hospital Association
John Alexander Mc Mahon, President, American Hospital Association

From: George F. Billington, President

Date: May 26, 1977

Enclosed you will find a copy of my statement opposing the Administration's H.R. 6575/S. 1391, the Administration's Hospital Cost Containment Act of 1977. I would appreciate your consideration and support in this matter.

George F. Billington
President
Union County Hospital Society
The Elizabeth General Hospital

GFB:an
Encl.

CALIFANO AND THE NINE PERCENT SOLUTION

STATEMENT REGARDING H.R.6575/S.1391

GEORGE F. BILLINGTON

PRESIDENT, UNION COUNTY HOSPITAL SOCIETY
PRESIDENT, ELIZABETH GENERAL HOSPITAL

ELIZABETH, NEW JERSEY

MAY 26, 1977

I am opposed to H.R.6575/S.1391. My opposition is based upon my conviction that this legislation is poorly conceived, that it will not accomplish what Health, Education, and Welfare Secretary Joseph A. Califano, Jr., proposes, and that it will produce adverse effects which he is deliberately ignoring--namely, it will reduce the quality of hospital care and be harmful to the health of the citizens of our nation.

H.R.6575/S.1391 will result in the chronic underfinancing of voluntary hospitals, reductions in personnel, deterioration of facilities, cutbacks and limitations in services, and the inability to attract and maintain qualified employees. Perhaps this is Secretary Califano's real objective.

My opposition centers around the points which follow.

* The application of price controls on one industry which must purchase goods, services, and labor from a free market is improper, unfair and unworkable.

* Faced with rising costs and insufficient revenue, hospitals will resort to crisis financial management, diverting resources from services which can ill afford to lose them, and closing other services.

* The legislation will require hospitals to limit or refuse non-emergency admissions as they approach their annual revenue quota.

* The legislation makes no provision for urban hospitals to recover their financial losses from care to the indigent.

* The legislation nakedly discriminates against the majority of the nation's hospitals by excluding federal hospitals.

* The legislation will impede health care innovation because of its strict control on revenue.

* Because the proposed cap on revenue by class of payor does not recognize demographic changes which are occurring in our society, the legislation will cause economically healthy hospitals to incur unhealthy deficits.

* The legislation disregards the demographic makeup of a hospital's service area through its arbitrary limits on numbers of beds and occupancy rates which will be established solely on the basis of population.

* The legislation ignores the efficiency of many hospitals and the successful cost containment they have accomplished.

* The legislation duplicates certificate of need and planning controls that are already in place through P.L. 93-641.

* The legislation does not consider the constitutional right of individuals to purchase whatever lawful services they desire.

* The legislation will create another mammoth bureaucracy within the Department of Health, Education, and Welfare. (<u>There are already 25 units within this one Department</u> concerned with some aspect of hospital affairs.)

* The legislation will create additional financial burdens upon hospitals, insurance carriers, and state governments as they add personnel to keep up with the red tape.

WHY HEALTH CARE COSTS HAVE RISEN

Hospital costs have risen sharply in recent years for reasons which are beyond the control of hospitals--and government, for that matter. In addition to the general inflation of the economy, hospitals have suffered extraordinary inflation in the "specialty" items they must purchase--items not required by "the average family of four." Hospital beds, hypodermic needles, dressings, and drugs are a few examples. The cost of petroleum-based products--the foundation of all our disposable items--has soared dramatically in recent years. These costs are beyond our control--we must pay fair market price. It is unfair to penalize hospitals for this inflation!

Public expectations of the health care system have impacted our costs through increases in our malpractice and liability insurance premiums and demands for outpatient primary care and community health education.

Hospital employees deserve salaries and benefits comparable to those in other industries. They should not be expected to subsidize the system through poverty wages.

Advancing technology accounts for sharp increases in health care costs. But the patients who benefit from fetal heart monitors, cardiac pacemakers, and chemotherapy will not agree that we should forego these advances in favor of lower costs.

But it must be emphasized that government itself, through mandated programs in areas ranging from energy use to employee

benefits to Medicare has increased our costs more than any other single force! This is not to say that government programs are not socially beneficial, but when Secretary Califano charges that federal, state, and local governments spent nearly $4 billion more for health care in 1976 than in the previous year, he should be reminded that this figure includes the swine flu fiasco, the additional thousands of people who became eligible for Medicare and Medicaid, the $2 billion that the government estimates to be wasted each year on Medicaid due to fraud and abuse, the costs of new government regulations and local public health projects. Most of this $4 billion increase was not caused by hospitals! Recently, Secretary Califano authorized new regulations regarding the handicapped which will cost hospitals billions of dollars in compliance!

Don't blame hospitals for costs that government creates!

As long as our economy and our government continue their current course, hospital costs will continue to increase, regardless of a cap on hospital revenue, and regardless of government controls.

THE ERRORS OF H.R.6575/S.1391

The application of a revenue cap upon a hospital which must exist in a free market will force the hospital to cut corners in order to maintain economic stability. In an efficient hospital, such as Elizabeth General, that is dangerous. How does hospital management decide that a nurse is more essential in a "life or

death" intensive care unit rather than in an oncology unit? Should outpatient clinics, which are the only source of health care for underprivileged patients, be closed because they represent an operating loss? Should housekeeping and maintenance services be curtailed, thereby increasing the risk of infection to patients? Should the purchase of intravenous solution be halted because the cost has increased 25 percent in the last eight months and Secretary Califano is only allowing 9 percent? These are the kinds of choices that will face hospital managements across the country if revenue is capped.

The stipulation that a hospital cannot exceed its revenue limit unless there are "changes in the capacity or character of inpatient services" or "major renovation of the physical plant" demonstrates conspicuously that sick people will be most hurt by this legislation! By threatening hospitals with an excise tax if they exceed a certain revenue quota, the legislation will force them to refuse to admit patients. This is grossly unfair to the patient who is nevertheless paying his health insurance premium and who is entitled to medical care when he needs it.

The revenue quota undermines the growing movement among consumers to shop around and make their own health care decisions. Let me explain. Two years ago, Elizabeth General completed a renovation of its obstetrical unit to complement a program of family-centered maternity care. If the popularity of our obstetric service continues to spread as rapidly as it is now, because of the Califano cap, we may find ourselves in the posi-

tion of having to say "no" to a patient--even though we may have room for her. That is a public disservice!

Likewise, the public cannot rest assured that they will receive service at a hospital with a reputation for outstanding cardiac or respiratory service, or for the quality of its nursing care. The hospital may be approaching its revenue cap!

The application of the cap is upon CLASSES of payors, not only upon total revenue. That means a hospital can admit only a limited number of Blue Cross, Medicaid, or privately insured patients. This provision reflects a shocking indifference to the social and demographic changes that are taking place in our society. One needn't be a genius to recognize that the population in the United States is aging, or that the middle class is fleeing the cities. Our population is growing older, and it's obvious that each year some Blue Cross subscribers are becoming Medicare clients. Our middle class is moving to the suburbs, and there is a shift in the proportion of private paying and Medicaid patients. Where will patients turn if a hospital is capped on the number of Medicare or commercially-insured patients it can accept? Is Secretary Califano prepared to tell people not to grow older? Or that they should earn more money so they can buy Blue Cross coverage? Or that they should earn less money so they can qualify for Medicaid?

Because of the strict limitations on revenue, hospitals will be discouraged from continuing their current efforts which will pay off in future health care savings to the public. Under

this legislation, hospitals will be left with no working capital to develop innovative programs, for example, in the areas of outpatient services or community health education. There is no incentive to adapt services to the changing needs of local communities.

Most New Jersey hospitals provide medical care without regard to ability to pay. We do not refuse anyone who is sick. This is a tradition of which Elizabeth General is proud. Yet, the fact remains that we, along with many other hospitals, lose hundreds of thousands of dollars each year through inpatient and outpatient service to the poor. In 1976, Elizabeth General provided $900,000 worth of care to the medically indigent. We received a $400,000 appropriation from our county board of freeholders. That means we had to recover $500,000 through other means. Hospitals have traditionally made up this loss through charitable contributions but in these difficult economic times, donations are not readily available. As a result, Elizabeth General suffered a substantial operating deficit in 1976.

The Califano legislation makes no provision for hospitals to recover these losses. There is no leeway to spread the increased costs of indigent care to other payors or to increase revenue in some other way in order to make up the loss. An arbitrary cap on revenue will force hospitals to reevaluate the economic soundness of some of their programs and to make "survival" decisions about health care. Let Secretary Califano deny that the poor will suffer!

The flagrant disregard by the Califano Administration for the health care needs of our citizens and the immediate political gains it foresees through H.R.6575/S.1391 is demonstrated in the shocking exemption of federal hospitals from this legislation! If a 9 percent cap makes any sense for any hospital, it makes sense for governmental hospitals. The arrogance of this exemption is insulting and infuriating! While federal hospitals are exempt, the rest of the nation's hospitals--rural, public, general, specialty, and teaching--where the bulk of the care is provided--are lumped into one category--their individual characteristics are ignored. If H.R.6575/S.1391 becomes law, the result will be two levels of hospital care in this country: the politically powerful will be treated at Bethesda Naval Medical Center and Walter Reed Army Hospital where the highest quality of care will be maintained and the latest lifesaving devices and techniques will be available; the rest of the people will be treated at the general care hospitals where quality has been "checked" along with revenue.

The social and demographic makeup of the individual hospital's service area is again ignored by the Califano bureaucracy in the planning section of the bill. The expansion of the health care system should be orderly and well-planned, but blanket assumptions about the necessary ratio of beds per population or rates of occupancy cannot be applied equally to institutions as different as Memorial Sloan-Kettering Cancer Center, Louisville General Hospital, and UCLA Medical Center. Each of these

hospitals serves a different purpose and patient. Furthermore, even if one were to compare only private, general hospitals, rigid standards still would not make sense. A suburban hospital, which serves a youthful population, may not need the same ratio of medical-surgical beds as a community hospital serving an older, retired population. An urban hospital may need a greater number of beds for emergency admissions. A state mental hospital may have still another set of needs to consider. This is a big country with 6,000 hospitals that do a lot of different things--it's preposterous to judge them all by the same standards.

The certificate of need provision in H.R.6575/S.1391 duplicates controls that are already part of P.L. 93-641. Some of these controls may not yet have been implemented, but they exist. The State of New Jersey has had strict certificate of need and planning controls in place since 1971. Contrary to what Secretary Califano would like the public to believe, no hospital in New Jersey is out buying CAT scanners and neutron radiation therapy units without regional consideration and state approval.

In its across-the-board application of a nine percent cap and the assumption of widespread hospital inefficiency, the Califano Administration ignores and insults those who have worked diligently over the years to upgrade the standards of patient care and hospital management and to balance social commitments with sensible business practices. It penalizes those

who operate efficient hospitals. These institutions will be the hardest hit if this proposal becomes law.

At Elizabeth General Hospital, we have been in cost containment for years. We have realized significant savings in energy, manpower, and supplies. We use many disposable products which eliminate the need for manpower to clean, sterilize, package and prepare materials. Our employees just concluded a six-week LEAN project (Learn Economy Answers Now) in which they were encouraged to analyze their own work situations and recommend money-saving techniques. The results have been encouraging.

The New Jersey Hospital Association has formed a multi-million-dollar group purchasing program for equipment, furniture, and pharmaceuticals. Our shared computer service is one of the lowest-cost data processing services of its kind.

My point is that there isn't any "fat" that can be trimmed at Elizabeth General Hospital.

H.R.6575/S.1391 will create a red tape nightmare beyond anything we've seen to date. The existing Medicare/Medicaid paperwork situation is no sweet dream. In addition to the people who were hired at state and federal levels to manage the Medicare and Medicaid programs, the hospitals and insurance carriers assumed additional burdens. At Elizabeth General, we had to hire four additional people just to handle Medicare paperwork. If each of them makes $8 thousand per year, they add $32 thousand per year to our budget. Multiply that by some 6,000 hospitals in the country and that's $192 million that Medicare costs our

hospitals just to push paper! Elizabeth General also had to hire one additional person to comply with requirements for utilization review and length of stay. Two additional accountants are being hired to keep up with the added volume of work associated with New Jersey's rate-setting system. Because of government regulations, hospitals are allocating more and more of the health care dollar to paperwork--to the detriment of patient services.

If H.R.6575/S.1391 becomes law, hospitals, the federal government, state governments, and the insurance people will all hire more accountants, lawyers, and secretaries. For what? To hold down costs?

In summary, we adhere to strict certificate of need controls; we carefully develop and follow our long-range plans; we make every attempt to stay within the limits of our budgets. Elizabeth General Hospital is doing everything possible to control its costs. To place an additional, arbitrary cap on our revenue will force us to impose austerity where austerity does not belong.

The bureaucracy at HEW is consumed with the passion for regulation. Already, there is enough regulatory authority in effect in this country to stem the rising cost of health care, if it is rationally applied.

Members of the Committee, I share your concern over rising health care costs. I am confident that you share my concerns over the quality and availability of hospital services.

H.R.6575/S.1391 is a simple-minded solution to a very complex problem. It won't hold down costs. Hospitals will be damaged. Health care services will be reduced. I urge you to defeat this proposal. Then, let's talk sense about hospital costs.

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CALIFANO AND THE NINE PERCENT SOLUTION

STATEMENT REGARDING H.R.6575/S.1391

GEORGE F. BILLINGTON

PRESIDENT, UNION COUNTY HOSPITAL SOCIETY
PRESIDENT, ELIZABETH GENERAL HOSPITAL

ELIZABETH, NEW JERSEY

MAY 26, 1977

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Hospital costs have risen sharply in recent years for reasons which are beyond the control of hospitals--and government, for that matter. In addition to the general inflation of the economy, hospitals have suffered extraordinary inflation in the "specialty" items they must purchase--items not required by "the average family of four." Hospital beds, hypodermic needles, dressings, and drugs are a few examples. The cost of petroleum-based products--the foundation of all our disposable items--has soared dramatically in recent years. These costs are beyond our control--we must pay fair market price. It is unfair to penalize hospitals for this inflation!

Public expectations of the health care system have impacted our costs through increases in our malpractice and liability insurance premiums and demands for outpatient primary care and community health education.

Hospital employees deserve salaries and benefits comparable to those in other industries. They should not be expected to subsidize the system through poverty wages.

Advancing technology accounts for sharp increases in health care costs. But the patients who benefit from fetal heart monitors, cardiac pacemakers, and chemotherapy will not agree that we should forego these advances in favor of lower costs.

But it must be emphasized that government itself, through mandated programs in areas ranging from energy use to employee

benefits to Medicare has increased our costs more than any other single force! This is not to say that government programs are not socially beneficial, but when Secretary Califano charges that federal, state, and local governments spent nearly $4 billion more for health care in 1976 than in the previous year, he should be reminded that this figure includes the swine flu fiasco, the additional thousands of people who became eligible for Medicare and Medicaid, the $2 billion that the government estimates to be wasted each year on Medicaid due to fraud and abuse, the costs of new government regulations and local public health projects. Most of this $4 billion increase was not caused by hospitals! Recently, Secretary Califano authorized new regulations regarding the handicapped which will cost hospitals billions of dollars in compliance!

Don't blame hospitals for costs that government creates!

As long as our economy and our government continue their current course, hospital costs will continue to increase, regardless of a cap on hospital revenue, and regardless of government controls.

THE ERRORS OF H.R.6575/S.1391

The application of a revenue cap upon a hospital which must exist in a free market will force the hospital to cut corners in order to maintain economic stability. In an efficient hospital, such as Elizabeth General, that is dangerous. How does hospital management decide that a nurse is more essential in a "life or

death" intensive care unit rather than in an oncology unit? Should outpatient clinics, which are the only source of health care for underprivileged patients, be closed because they represent an operating loss? Should housekeeping and maintenance services be curtailed, thereby increasing the risk of infection to patients? Should the purchase of intravenous solution be halted because the cost has increased 25 percent in the last eight months and Secretary Califano is only allowing 9 percent? These are the kinds of choices that will face hospital managements across the country if revenue is capped.

The stipulation that a hospital cannot exceed its revenue limit unless there are "changes in the capacity or character of inpatient services" or "major renovation of the physical plant" demonstrates conspicuously that sick people will be most hurt by this legislation! By threatening hospitals with an excise tax if they exceed a certain revenue quota, the legislation will force them to refuse to admit patients. This is grossly unfair to the patient who is nevertheless paying his health insurance premium and who is entitled to medical care when he needs it.

The revenue quota undermines the growing movement among consumers to shop around and make their own health care decisions. Let me explain. Two years ago, Elizabeth General completed a renovation of its obstetrical unit to complement a program of family-centered maternity care. If the popularity of our obstetric service continues to spread as rapidly as it is now, because of the Califano cap, we may find ourselves in the posi-

tion of having to say "no" to a patient--even though we may have room for her. That is a public disservice!

Likewise, the public cannot rest assured that they will receive service at a hospital with a reputation for outstanding cardiac or respiratory service, or for the quality of its nursing care. The hospital may be approaching its revenue cap!

The application of the cap is upon CLASSES of payors, not only upon total revenue. That means a hospital can admit only a limited number of Blue Cross, Medicaid, or privately insured patients. This provision reflects a shocking indifference to the social and demographic changes that are taking place in our society. One needn't be a genius to recognize that the population in the United States is aging, or that the middle class is fleeing the cities. Our population is growing older, and it's obvious that each year some Blue Cross subscribers are becoming Medicare clients. Our middle class is moving to the suburbs, and there is a shift in the proportion of private paying and Medicaid patients. Where will patients turn if a hospital is capped on the number of Medicare or commercially-insured patients it can accept? Is Secretary Califano prepared to tell people not to grow older? Or that they should earn more money so they can buy Blue Cross coverage? Or that they should earn less money so they can qualify for Medicaid?

Because of the strict limitations on revenue, hospitals will be discouraged from continuing their current efforts which will pay off in future health care savings to the public. Under

this legislation, hospitals will be left with no working capital to develop innovative programs, for example, in the areas of outpatient services or community health education. There is no incentive to adapt services to the changing needs of local communities.

Most New Jersey hospitals provide medical care without regard to ability to pay. We do not refuse anyone who is sick. This is a tradition of which Elizabeth General is proud. Yet, the fact remains that we, along with many other hospitals, lose hundreds of thousands of dollars each year through inpatient and outpatient service to the poor. In 1976, Elizabeth General provided $900,000 worth of care to the medically indigent. We received a $400,000 appropriation from our county board of freeholders. That means we had to recover $500,000 through other means. Hospitals have traditionally made up this loss through charitable contributions but in these difficult economic times, donations are not readily available. As a result, Elizabeth General suffered a substantial operating deficit in 1976.

The Califano legislation makes no provision for hospitals to recover these losses. There is no leeway to spread the increased costs of indigent care to other payors or to increase revenue in some other way in order to make up the loss. An arbitrary cap on revenue will force hospitals to reevaluate the economic soundness of some of their programs and to make "survival" decisions about health care. Let Secretary Califano deny that the poor will suffer!

p.8

The flagrant disregard by the Califano Administration for the health care needs of our citizens and the immediate political gains it foresees through H.R.6575/S.1391 is demonstrated in the shocking exemption of federal hospitals from this legislation! If a 9 percent cap makes any sense for any hospital, it makes sense for governmental hospitals. The arrogance of this exemption is insulting and infuriating! While federal hospitals are exempt, the rest of the nation's hospitals--rural, public, general, specialty, and teaching--where the bulk of the care is provided--are lumped into one category--their individual characteristics are ignored. If H.R.6575/S.1391 becomes law, the result will be two levels of hospital care in this country: the politically powerful will be treated at Bethesda Naval Medical Center and Walter Reed Army Hospital where the highest quality of care will be maintained and the latest lifesaving devices and techniques will be available; the rest of the people will be treated at the general care hospitals where quality has been "checked" along with revenue.

The social and demographic makeup of the individual hospital's service area is again ignored by the Califano bureaucracy in the planning section of the bill. The expansion of the health care system should be orderly and well-planned, but blanket assumptions about the necessary ratio of beds per population or rates of occupancy cannot be applied equally to institutions as different as Memorial Sloan-Kettering Cancer Center, Louisville General Hospital, and UCLA Medical Center. Each of these

hospitals serves a different purpose and patient. Furthermore, even if one were to compare only private, general hospitals, rigid standards still would not make sense. A suburban hospital, which serves a youthful population, may not need the same ratio of medical-surgical beds as a community hospital serving an older, retired population. An urban hospital may need a greater number of beds for emergency admissions. A state mental hospital may have still another set of needs to consider. This is a big country with 6,000 hospitals that do a lot of different things--it's preposterous to judge them all by the same standards.

The certificate of need provision in H.R.6575/S.1391 duplicates controls that are already part of P.L. 93-641. Some of these controls may not yet have been implemented, but they exist. The State of New Jersey has had strict certificate of need and planning controls in place since 1971. Contrary to what Secretary Califano would like the public to believe, no hospital in New Jersey is out buying CAT scanners and neutron radiation therapy units without regional consideration and state approval.

In its across-the-board application of a nine percent cap and the assumption of widespread hospital inefficiency, the Califano Administration ignores and insults those who have worked diligently over the years to upgrade the standards of patient care and hospital management and to balance social commitments with sensible business practices. It penalizes those

who operate efficient hospitals. These institutions will be the hardest hit if this proposal becomes law.

At Elizabeth General Hospital, we have been in cost containment for years. We have realized significant savings in energy, manpower, and supplies. We use many disposable products which eliminate the need for manpower to clean, sterilize, package and prepare materials. Our employees just concluded a six-week LEAN project (Learn Economy Answers Now) in which they were encouraged to analyze their own work situations and recommend money-saving techniques. The results have been encouraging.

The New Jersey Hospital Association has formed a multi-million-dollar group purchasing program for equipment, furniture, and pharmaceuticals. Our shared computer service is one of the lowest-cost data processing services of its kind.

My point is that there isn't any "fat" that can be trimmed at Elizabeth General Hospital.

H.R.6575/S.1391 will create a red tape nightmare beyond anything we've seen to date. The existing Medicare/Medicaid paperwork situation is no sweet dream. In addition to the people who were hired at state and federal levels to manage the Medicare and Medicaid programs, the hospitals and insurance carriers assumed additional burdens. At Elizabeth General, we had to hire four additional people just to handle Medicare paperwork. If each of them makes $8 thousand per year, they add $32 thousand per year to our budget. Multiply that by some 6,000 hospitals in the country and that's $192 million that Medicare costs our

p.11

hospitals just to push paper! Elizabeth General also had to hire one additional person to comply with requirements for utilization review and length of stay. Two additional accountants are being hired to keep up with the added volume of work associated with New Jersey's rate-setting system. Because of government regulations, hospitals are allocating more and more of the health care dollar to paperwork--to the detriment of patient services.

If H.R.6575/S.1391 becomes law, hospitals, the federal government, state governments, and the insurance people will all hire more accountants, lawyers, and secretaries. For what? To hold down costs?

In summary, we adhere to strict certificate of need controls; we carefully develop and follow our long-range plans; we make every attempt to stay within the limits of our budgets. Elizabeth General Hospital is doing everything possible to control its costs. To place an additional, arbitrary cap on our revenue will force us to impose austerity where austerity does not belong.

The bureaucracy at HEW is consumed with the passion for regulation. Already, there is enough regulatory authority in effect in this country to stem the rising cost of health care, if it is rationally applied.

Members of the Committee, I share your concern over rising health care costs. I am confident that you share my concerns over the quality and availability of hospital services. H.R.6575/S.1391 is a simple-minded solution to a very complex problem. It won't hold down costs. Hospitals will be damaged. Health care services will be reduced. I urge you to defeat this proposal. Then, let's talk sense about hospital costs.

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UNITED MINE WORKERS OF AMERICA
HEALTH AND RETIREMENT FUNDS

BEFORE
THE

U. S. SENATE SUBCOMMITTEE
AND HEALTH AND SCIENTIFIC RESEARCH

EDWARD M. KENNEDY, CHAIRMAN

WEDNESDAY, MAY 31, 1977

TO: U. S. SENATE SUBCOMMITTEE AND HEALTH AND SCIENTIFIC RESEARCH

CHAIRMAN: EDWARD M. KENNEDY

May 31, 1977

The United Mine Workers of America Health and Retirement Funds submit the following statement regarding Senate Bill 1391, The Hospital Cost Containment Act of 1977.

The United Mine Workers of America Health and Retirement Funds are successors to the original Welfare and Retirement Fund established by the Krug-Lewis Agreement in 1946. The Funds provide health and pension benefits to a population of over 800,000 coal miners, retired and disabled miners, and their dependents, living in all 50 states, but concentrated in the coal field areas of Appalachia, the Upper Mississippi Valley, and the rural West.

The Funds are multi-employer joint Trusts established under Section 302 of the Taft-Hartley Act. The agreements under which we operate are adopted as part of the collectively-bargained wage agreements between the United Mine Workers of America, the Bituminous Coal Operators Association, the Association of Bituminous Contractors, and individual coal operators and coal haulers. Eligibility, benefit limits, and rates of payment from the signatory companies are established prospectively for the term of the collective bargaining agreement by the Trusts' settlors. The Funds are administered by a three-member Board of Trustees.

As you know, coal mining is one of the most dangerous occupations in the United States, and it should therefore be no surprise that our population has a very high rate of medical

problems which require professional care. The high incidence of disease and accidents, coupled with the traditionally poor access to medical care in the rural areas we serve, and compounded by other hardships of rural and mountain life, have made the 30 years of the Funds' medical program a unique chapter in American health care.

Our program is costly, but not excessive in terms of national figures. In 1976, the Funds paid out almost 225 million dollars for health care for our covered population, about 45 million dollars of that for beneficiaries on Medicare.

The Funds are not a direct provider of medical care; we own no hospitals or facilities and employ no health care providers. (Although, the Funds did establish and operate the Miners Memorial Hospitals, these were sold in 1963 to the Appalachian Regional Hospitals, Incorporated).

Thus we are continuously faced with the challenge of how we can use purchasing power and administrative interventions to make quality care accessible and available to our primarily rural beneficiary population, while at the same time controlling costs.

Our reimbursement mechanisms include both fee-for-service and cost based arrangements. We have used our purchasing power to encourage the development of group practices and non-profit community clinics, modes of delivery we tend to favor. Administratively, we have created a limited list of participating

providers based on need, quality, administrative compliance and costs. We have also administratively imposed a prior approval requirement for certain procedures such as tonsillectomies and adenoidectomies and have been one of the first third parties to only reimburse for drugs prescribed from a limited formulary. We have also aggressively, but sadly, unsuccessfully, fought against construction of unnecessary hospital beds.

We have long fought for one level of benefits and care for all of our beneficiaries regardless of age or location. This philosophy has led us to a rather unique arrangement with the Social Security Administration for our Medicare enrolled beneficiaries, which now number more than 120,000. While the Funds pay the Medicare Part A deductibles and coinsurance, the unique aspect of our Medicare program is that we pay for all Part B services for these beneficiaries as a Group Practice Prepayment Plan dealing directly with the Social Security Administration.

Under this G.P.P.P. arrangement, physicians and clinics make no distinction between our beneficiaries who are Medicare enrolled and those who are not. All services are billed directly to the Health and Retirement Funds according to a predetermined reimbursement plan based either on cost or fee-for-service. We, in turn, allocate our expenditures for our Medicare enrolled beneficiaries to a Medicare account and receive monthly reimbursement from the Social Security Administration for our costs, both direct and indirect.

There are several advantages to this arrangement. For the physician or clinic the administrative conveniences are significant. The beneficiary, since we pay all coinsurance and deductibles, never has to become involved in the payment cycle. From a systems perspective, the arrangement is particularly attractive in that all of our beneficiaries, Medicare eligible or not, have a single level of coverage, and the subtle incentives toward two levels of care that may be caused by two reimbursement mechanisms are nonexistant.

Our concern with rising health care costs and with the systems used to pay for health care services derive from our purposes as stated in the Trust document:

1. Provide beneficiaries of the Trusts with quality health care;

2. Improve the delivery of quality health care services;

3. Assist beneficiaries in solving their health needs through education and prevention measures;

4. Assist the beneficiaries, wherever practical, in improving their general health and living conditions.

These general goals are, however, constrained by the fixed level of income to the Funds set by the Wage Agreement. In this regard, we are in a position similar to the thousands of other jointly-administered Trusts established under Taft-Hartley and covered by ERISA.

The Health and Retirement Funds of the UMWA endorse the intent of S. 1391. However, we fear that effective control of hospital costs may not be achieved even on a limited and transient basis by this Bill.

Before addressing the Bill directly, I will emphasize four points which we believe must be on the public policy agenda whenever cost and quality of health care are at issue:

1. Should there be a limit set on the percentage of gross national product devoted to health or, more appropriately, medical care?

   Over the last 25 years the percentage of our gross national product devoted to medical care has about doubled. There have been some noteworthy recently reported changes in health status - increased length of life, decreased infant mortality as well as mortality changes associated with certain diseases. Uncritically attributing these changes, in whole or even in substantial part, to increased investments in medical care is fraught with hazard and may very well be unwarranted. In any case we need to ask can some portion of this investment be put to a better use - other social programs, transportation, or even mitigation of tax increases? We feel that continued increases in the percentage of gross national product devoted to health should not be taken automatically as either good or as a given. Mechanisms for stabilization or even reduction merit discussion and consideration.

2. Physician Oversupply

Health care policy and cost containment strategies must address physician oversupply. Although there are many areas of America, both rural and inner city where there is a lack of physician manpower, in aggregate we may already be in a physician oversupply situation. Certainly by 1985 we will be in such a situation with a projected physician to population ratio of 1/560.

The consequences of this oversupply combined with the current open ended financing mechanism, largely under physician control, will assure a continued cost push with each physician generating from twice to perhaps four times his annual income in total costs to the health system each year. Parenthetically and sadly, such oversupply will not only be costly but is unlikely to result in any significant redistribution of services to rural and under served inner city areas or in any overall increase in the general level of health or well being.

3. Hospital Bed Supply and New Technology

Controlling hospital bed supply, and, in fact, reducing existing acute hospital beds, is a necessary part of any cost control strategy. S.1391, particularly in Title II, recognizes the importance of controlling bed

supply. The tight limits it would place on capital expenditures should, over time, contribute to a reduction in existing acute bed supply.

At this time it is appropriate to emphasize the need for rigorous constraints on high cost hospital services. Sufficient forces from the public, planning authorities, and payors must be developed that will stimulate hospitals to adopt management policies that:

- o Promote sound cost effect decision making within each hospital;
- o Require that each hospital view itself as a part of the overall care system in its region and, therefore, develop mechanisms for shared services and non-duplication of high cost technology.

Not only is there a cost control benefit from controlling hospital bed supply but such control eventually can contribute to the development of a more appropriate mix of services emphasizing ambulatory and preventive care.

4. <u>The relationship of payment mechanisms to forces contributing to increased hospital costs</u>

Many theories have been advanced to explain the recent inflation in hospital costs. Two characteristics of the

> hospital economic environment underlying some of the theories are (a), the relative weakness of the competitive market system within the health delivery environment as an incentive for efficiency, and (b), the growth of third party financing for hospital services. Emphasis has been placed on the reimbursement mechanism because the present retroactive actual cost reimbursement system used by Medicare and most third parties is not an effective substitute pricing mechanism for providing efficiency incentives. Rather, the cost system is one of the basic contributing factors to increased hospital costs. It introduces few financial constraints into the decision making process within hospitals. It neither rewards decision makers for efficient management of resources nor does it provide a basis for holding them accountable for such management.

One way to address the inherent weaknesses in cost based retroactive payment is through prospective reimbursement to providers. The Funds have had experience in this area and despite problems, some serious, remain convinced that hospitals are particularly good candidates for prospective reimbursement.

We expect to continue developing and, as feasible, expand prospective reimbursement approaches in the Funds. Why? Prospective reimbursement has at least the following advantages:

- Agreement on the output or service mix of a given program within the framework of regionally established age and service specific utilization goals is possible.

- Management has greater operating flexibility as resources are known and available in advance.

- Incentives for efficiency are present if cost savings are shared with programs. This can be a real stimulus to management as the impact of cost savings in part are returned to the program which incurred the savings.

- The payor can predict and budget for expenses in advance.

Prospective reimbursement has, in our judgment, its greatest potential when likened to risk sharing and ambulatory care as in the prepaid group practice model.

We suggest the four major points just outlined -

- Controlling the percentage of gross national product devoted to health
- Physician oversupply
- Hospital beds and new technology
- Payment mechanisms

should be considered as any particular cost control approach is developed.

Title I of, S. 1391, as currently drafted, though laudable in intent, will not work. Title II, though rigorous, appears feasible, reasonable and desirable. Some specific comments:

- o In general, it will be very difficult to regulate one sector of the economy when the rest of the economy is substantially non-regulated and still more difficult to regulate one component--hospitals and their cost.

- o The concept of a cap does not seem valid. Rather, this Bill guarantees a floor and defines various ways in which the ceiling can be raised. If this Bill were to pass, for all practical purposes we can assume that 9% per year annual cost growth would be a minimum guaranteed by the government. The variety of extenuating circumstances defined within the proposed legislation will result in cost escalation well beyond 9% much of the time.

- o Section 111 appears to reward those hospitals whose cost increases in the past two years have been highest.

- o There is no recognition that at the present level of funding hospitals may well be "fat". For example, the United States ratio of hospital employees to beds is about twice that of some Western European countries and there is little evidence to suggest that we are better served by such staff intensity.

Lean management and supervisory staff and highly productive workers are not encouraged by this Bill. In fact existing staffing patterns may be stabilized. It is our belief that in many hospitals service content and quality could be maintained with, in constant dollar terms, stable or even slightly reduced total revenues. Overall we believe that total spending for hospitals could be significantly reduced with no adverse effect - perhaps even a positive effect - on health status.

- From our reading of S.1391, it appears the Bill may be dangerously silent with regard to proprietary hospitals engaging in ownership transfers with excessive profit-taking passed into the reimbursement mechanisms analogous to what used to be a common nursing home practice.

- The Bill calls on each third party to control its own payment increases. This requires coordination of activities between third parties in order to determine whether actual increases are within the proposed law. Such coordination on a hospital-by-hospital basis between Medicare, Medicaid, the Blues, and private insurers is probably not feasible within the lifetime proposed by the legislation. Further, this is made even more difficult as the current charge structure is such that the same service may well be billed at

different rates to different payors. As a minimum, charges for the same service should be the same to all payors (public and private third parties and individuals). More basically, the relationship of charges to cost must soon be comprehensively addressed.

- It appears there is a strong incentive in the Bill for hospitals to increase their admissions of "low cost" patients. Section 113 could result in needless admissions and needless procedures sufficient to qualify the hospital for revenue increases. Such admissions would be in the hospital's interest so long as the average cost of new admissions were no more than 50% of the revenue from the average cost of admissions in the base year.

- The Bill calls upon the Health Systems Agencies for various functions in both Titles. These agencies now have very limited capacity and if they are to contribute in any effective way have to be strengthened. This will require the authorization and appropriation of funds for additional personnel. As capacity building is not just acquisition of staff but also the development of specific technical approaches within each HSA, this will take time - probably two to three years at best.

- Title I of S.1391 is not administratively simple. Our experience as a major payor suggests it will be

complex and potentially impossible to administer, particularly within the time frame called for within the legislation.

- It appears perfectly possible that a hospital trying to improve its overall cost effectiveness, reduce needless admissions and control introduction of inappropriate technology could very well be hard hit by this legislation while the inefficient hospital seeking ways around the legislation, might benefit the most.

- The capital expenditure limits specified in the program are laudable and extremely rigorous. An expenditure limit of two and one-half billion dollars per year for capital investment will translate into virtually no new construction, some modernization and renovation of buildings and limited acquisition of new equipment.

- The figure of four beds per 1,000 at 80% occupancy is a reasonable starting point and allows for about 1.2 patient days per person per year. Longer range goals for the nation's current population mix could reasonably be expected to be below 1.0 day per person per year. Though still higher than much prepaid group practice experience this latter figure would require considerable reduction in existing acute bed supply but, in the long run, is essential for medical care cost control.

Are there alternatives possible for Title I? Effective short-term cost control measures directed only to the hospital component of the medical care sector to have some chance of success must be very straight forward, easy to administer, with little opportunity for exceptions. Unfortunately, and by their very nature, such measures would sometimes be inequitable if not clearly draconian. Perhaps Phase III of the Economic Stabilization Act could be quickly dusted off as a transition tactic more likely to work than Title I as proposed. It might make even better sense to wait for March 1978 as called for in the legislation and work with the Administration in developing a feasible, comprehensive and more permanent approach to medical care cost control.

In summary, the Health and Retirement Funds of the United Mine Workers supports the intent of S.1391. However, Title I is so seriously flawed we feel it should not receive favorable action in its present form. Title II, on the other hand, substantially strengthens certificate of need programs and is a major contribution to long-term cost control. Therefore, we favor its passage into law.

Thank you.

William J. Bicknell, M.D.
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June 3, 1977

The Honorable Edward Kennedy
Subcommittee Chairman
Subcommittee on Health and
Scientific Research
Room 310 B - Senate Courts
120 "C" Street, N.E.
Washington, D.C. 20510

Dear Senator Kennedy:

The United Societies of Physiotherapists, Inc. wishes to submit to the Subcommittee on Health and Scientific Research its response to the Carter Administration's Hospital Cost Containment Proposal, H.R. 6575. We will address ourselves specifically to the physical therapy component of hospital costs.

As noted in our testimony to the Subcommittee on Health on July 28, 1976 (copy of which is attached hereto), the hospitals too often use the traditional approach of staff personnel to providing physical therapy services in spite of the fact that in many cases this may be the least efficient and most expensive method of providing those services. The rigid structure of a salaried physical therapy department results in all professional personnel on salary, all equipment and ancillary services provided by the hospital and hours fixed regardless of patient load and the fluctuating requirements of treatment.

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Review of needs of the community can demonstrate that a much more efficient and far less costly means for a hospital to meet its physical therapy needs is to be serviced by private practitioners in the same manner as medical services are provided by the attending medical staff. Many hospitals now utilize the services of private physical therapy practitioners and the system works to the advantage of the institutions and its patients. The physical therapist receives no salary or fringe benefits and most often provides his own equipment. Hours are not fixed but, as with all private practitioners, treatments are rendered according to the needs of the patients involved. The patient load may require a relatively low volume or at times may necessitate high volume and the treatments are provided at night, on weekends and whenever required by the patient. In short, treatment hours are independent of artificial work schedules. The physical therapist bills patients directly for services rendered, absorbing all overhead, at fees (usually ranging from $15 - $25) far lower than the hospital's cost per treatment in salaried departments. Fees are only charged for the actual treatments given, and not for any specific hours spent in the institution or based on the totality of all institution services.

It is important to note here that the method of payment to the physical therapist does not affect quality and utilization control mechanisms. Whether the physical therapist is on salary or a member of the physical therapy attending staff, he is subject to the same

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requirements regarding record keeping and other quality and utilization control mechanisms. In fact, because the private practitioner is in fact in "practice" in that hospital and has a substantial investment there, the quality of care tends to be higher as the level of experience is greater, the necessity to provide good quality care inherent in any private practice is there and the constant turnover found in salaried departments is not a factor.

It is important to recognize that different hospitals have different requirements and should be free to meet their needs in the manner best suited for them, so long as they seek high quality at minimum cost. Long term, chronic care hospitals and some specialty hospitals have definite needs for full scale rehabilitation medicine departments. Short term, acute care hospitals have entirely different needs. The concern in these institutions is to provide intensive medical care to acutely ill patients and patients with recent injuries. Hospitals try to discharge these patients as soon as their medical condition permits. (Indeed, the Federal government has a timetable for each type of case strongly suggesting the proper length of acute hospital stay). Their care is continued in the office, at home on an outpatient basis, in a long term hospital or in a skilled nursing facility as the individual situation dictates. Physical therapy services in an acute care hospital should be adequate to service the often fluctuating needs of the patients but it is not always necessary or wise for acute care hospitals to have elaborate rehabilitation medicine departments that tend to increase the length of stay in the hospital and reduce the number of beds available to acutely ill patients. Many acute care hospitals recognize this and are drastically cutting down (or eliminating) their expensive rehabilitation medicine departments to more realistic levels.



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One factor that discourages hospitals from utilizing private physical therapy practitioners, in spite of the fact that in many cases the system would be ideal for that hospital, is the restrictive, unrealistic language in Section 251 (a) of PL92-603 which limits reimbursement of physical therapy services performed by independent practitioners to $100 per patient per calendar year and only if service is provided in the physical therapist's office or in the patient's home. This should be amended in two ways (1) remove the utterly outdated $100 limitation and (2) expand coverage to include physical therapy services provided in any locale, including hospitals. Hospitals should be encouraged to utilize less costly, higher quality systems rather than discouraged because of outdated Federal law.

Physical therapy care is a vital and integral part of the treatment of many patients. However, it should be carried out in the setting that is most beneficial to the patient. We should recognize that this is most achievable when the patient and his physician have maximum free choice in referral of physical therapy services and when costs for such services are directly related to the professional provision of services. Hospital costs are unquestionably far too high and we support the Administration's and the Congress' efforts to contain them. While we have limited ourselves to our own area of expertise, physical therapy services, it seems clear that significant savings could be effected in this area with a concomitant raising of the quality of care.

United Societies of Physiotherapists Inc.

We urge you to give serious consideration to these suggestions and we stand ready to assist in all possible ways.

Respectfully submitted,

Alan Leventhal, Ph. T., Chairman
Committee on National Legislative Matters

AL:eb
Encs.

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July 28, 1976

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Hon. Daniel Rostenkowski
Subcommittee Chairman
Subcommittee on Health
Committee on Ways and Means
1102 Longworth House Office Building
Washington D. C.- 20515

Dear Hon. Rostenkowski:

The United Societies of Physiotherapists, Inc. wishes to thank the members of the Subcommittee on Health for this opportunity to present testimony on the subject of factors contributing to the continuing rise in the costs of hospital care, and more specifically, to the physical therapy component of hospital costs. The following organizations join the United Societies of Physiotherapists, Inc. in this presentation:

Council of Licensed Physiotherapists of
New York State, Inc.
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1818 Newkirk Avenue
Brooklyn, New York 11226

New Jersey State Physical Therapy
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Patrick Trotta, Ph.T., President
4024 Taylor Road
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Physical Therapy Society of Pennsylvania
Alwen DeWald, Ph.T., President
1237 Oak Road
Pottsville, Pennsylvania 17901

Golden State Physical Therapy Association of
California, Inc.
Merlin L. Kemp. Ph.T., President
809 Chapala Street
Santa Barbara, California 93101

Rhode Island Physical Therapy Society, Inc.
Mildred Doane, Ph.T., President
133 Ansdale Road
Cranston, Rhode Island 02910

Massachusetts Society of Registered Physical Therapists
Walter Holder, Ph.T., President
480 Washington Street
Norwood, Massachusetts 02062

We wish to address ourselves to the topic of the continuing rise in hospital costs, specifically to the physical therapy component of those costs.

There are basically three systems used by hospitals to provide physical therapy services.

1. Salaried departments where all personnel are salaried by the hospital and all equipment and ancillary services are provided by the hospital. Department hours are usually fixed.

2. Contract departments where the hospital enters into an arrangement with an organization to provide physical therapy services. Usually, the equipment and ancillary services are provided by the physical therapy contracting organization. Department hours are flexible and extensive.

3. Hospitals serviced by privately practicing physical therapists who are members of the staff. The private practitioner receives no salary or other fringe benefits but bills the patients directly for services rendered. Equipment, here too, is usually provided by the private practitioner. Department hours are flexible and extensive.

Quality and utilization control mechanisms are not dependent upon the system of physical therapy department utilized but remain the same. The physical therapy department in each instance functions according to the proper legal and hospital requirements.

The salaried department is the least efficient and least productive type of department--and therefore the most costly. The most important item in figuring cost is the cost per unit of work. Salaried departments rate very poorly when this cost mechanism is used.

Contract departments fare better in this regard. As the only monies expended are for actual services rendered, the incentives for efficiency and superior service are higher than salaried departments. We do not here address ourselves to the ethics of contracting professional services to an unlicensed corporate entity. The drawback here is that the hospital is serviced by an organization rather than a professional individual and this tends to render the care somewhat more impersonal but still much better than in salaried departments. Contracting organizations have been severely hampered by being subject to the salary equivilency regulations required by PL 92-603 Sec. 251(c) The Bureau of Health Insurance's regulations implementing this section have mandated a time equivilency factor rather than a unit of work factor. This undercuts the whole basis of contracting organizations and makes their operations much more difficult. Senate Bill S. 3611 would tend to alleviate this particular situation by providing an alternative to salary equivilence on the basis of a cost per visit. This is an improvement but by no means solves the problem as it still makes for a most cumbersome reimbursement system with built-in uncertanties for both "provider" and physical therapist and still places the physical therapy practitioner under restrictions applicable to no other licensed health professional.

The private practitioners servicing the hospital provide the same benefits as the contracting organization but on an individual professional basis. Surveys have shown that private practitioners rate very highly among the most experienced and qualified practitioners in the profession. Their practice is built on skill and good results and cannot flourish without satisfying both the patient and the referring physician. Private practitioners allowed by the hospital to practice within its confines bring all the techniques and expertise into their hospital practice. They equip their own departments, absorb all overhead and bill the patients for services rendered. They relieve the hospital from any liability for costs but not from maintaining quality control and utilization control. Private practitioners are hampered because Sec. 251(a) of PL 92-603 does not allow for reimbursement for their



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services when performed in a hospital-only when performed in their offices or a patient's home. This is illogical, unfair and leads to unnecessarily increased costs.

We believe the Congress should take action to correct these inequities. Interpretations of 251(c) should be based on unit of work rather than time. Sec. 251(a) should be expanded removing the unrealistic $100 per patient per year limitation and expanding its provisions to cover hospital services. This would allow a free enterprise system in which different systems of physical therapy delivery could compete with each other and institutions could choose whichever system best suits their needs.

Respectfully submitted,

Alan Leventhal, Ph.T

National Legislative Chairman
Alan Leventhal, Ph.T.

UTAH STATE HOSPITAL ASSOCIATION

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June 14, 1977

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Salt Lake City, Utah

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Logan, Utah

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American Fork Hospital
American Fork, Utah

EXECUTIVE DIRECTOR

John R. Walker

Stuart Shapiro, M.D.
Subcommittee on Health and Scientific Research
Committee on Human Resources
U.S. Senate
Washington, D.C. 20510

Dear Dr. Shapiro:

We want to inform you that the Board of Trustees of the Utah State Hospital Association on behalf of the hospitals of Utah, acted on May 13 to totally oppose H.R. 1391, and the revenue and capital control concepts which it embodies. This proposal would if adopted and enforced for a period of time, endanger the very existence of our hospitals, and would immediately harm the quality of patient care by forcing cut-backs in services. Hospitals face cost increases of over 10% per year due purely to inflation, and if revenue increases are restricted by this bill to less than 9% we must obviously offer less service, less quality, less cure. Health care has made great strides in the past decade. Most of the drugs in our hospitals pharmacy were not in use 10 years ago; surgical techniques only used experimentally then are commonplace now such as various open heart surgeries, joint and hip replacements, and organ transplants; and coronary care and intensive care units are now the standard of care, not the exception. These improvements in care would not have been possible if hospitals had been forced to limit revenue to only a pass through of inflationary cost or less. And equally true, no quality improvements or new processes may be accommodated in the future with these kinds of controls. We see this as the most damaging proposal our hospitals have ever faced.

We feel that the bill is both inept and unfair. The complex revenue control formula combining base line data adjusted to the Gross National Product Deflator and further adjusted to increases or decreases in hospital admissions would be an administrative nightmare for hospitals, fiscal intermediaries, and governmental agencies. The controls proposed do not recognize the many differences in hospitals due to size, location, and scope of service, and as a result the bill would penalize hospitals that are the most efficient and those where the service demands are the highest. This is certainly not compatible with locally determined community obligations and needs. To illustrate the injustice of the bill, we would like to cite the following statistics and examples:

1. The average length of stay in acute care hospitals in Utah is 5.6 days as opposed to 7.7 nationally. The stay in some eastern regions is 8.0 to 9.2 days. The bill proposes caps of 9% or less on revenue linked to admissions. Hospitals with a long average length of stay could theoretically reduce this length of stay, increase rates and still meet the caps. Our hospitals, with length of stay at an irreducible minimum cannot make such an adjustment and will be punished for their past effectiveness. For example, a hospital with an 8 day average length of stay charging $150 per day average rate would generate $1200 per admission.

By reducing the length of stay to 6 days this hospital could increase per diem charges to $200 and still only generate $1200 revenue per admission. This rate increase from $150 to $200 per day would most adequately cover the impact of inflation on this hospital, and the impact of the caps would be nil. The hospital that has a 5.6 day average length of stay prior to the controls has nothing to reduce but its quality and capability to serve. This is shabby treatment for a hospital that has been charging only $840 per admission to Medicare and Medicaid rather than $1200 to begin with. (5.6 x $150 = $840 using the same initial per diem charge.)

2. The average case cost or cost per hospital admission in Utah is about $750 compared to $1100 nationally. It is obvious that the problem presented in the previous theoretical example is in reality understated. We used in the previous example the same per diem or daily rate for both hospitals - only the length of stay varied. Actually, our Utah hospitals are charging less per day as well as providing a shorter length of stay than the national average with a resulting lower cost per case for admission of $750 compared to $840 used in the example. These favorable rates are in part because of generally better productivity in relation to wages in Utah hospitals and in part because of long standing cost containment activities of our hospitals including effective management support and shared services activities. Over two-thirds of our Utah hospitals are part of multi-hospital management groups and benefit from central management services. Nearly all of our hospitals participate in shared services programs to cut costs, such as group purchasing, collections, management engineering and data processing. Again we must point out that our hospitals because of their past cost effectiveness will be penalized by the S.1391 proposal as compared to hospitals with higher costs and a higher cost base data year that may be able to now utilize some cost containment activities in order to accommodate to the revenue caps.

3. Rural hospitals in Utah and in neighboring states, regularly refer many patients to the metropolitan Salt Lake hospitals; University of Utah Hospital, Primary Children's Medical Center, L.D.S. Hospital, Holy Cross Hospital, and St. Mark's Hospital. These referrals are based on medical need as the Salt Lake hospitals have the sophisticated equipment and staff to deal with the more complex and critical patients. S. 1391 with its incentives to stabilize or reduce admissions would provide incentives to these rural hospitals to accelerate this referral process with very serious consequences to the receiving hospital. Potentially, a traumatic tug of war to refer or resist referral could disrupt carefully constructed medical petterns and be harmful to proper patient care.

4. Utah, and the West in general are growing much faster than most of the rest of the country. Some of our rural communities are increasing population rapidly and will expand even more in the future as energy demands increase as coal, oil and uranium resources are exploited. This growth is increasing admissions in our hospitals by about 3-4% per year now, and some hospitals anticipate increased admissions of 10% or more in the year or two ahead. The most dramatic increases are likely to be in the more rural and remote areas, where both the local community and the federal government have been for years trying to improve and expand access to care. Hill-Burton capital funds for construction and renovation, National Health Service Corps Physician commitments, Family Practice medical training, and other programs have all been directed toward these ends. Some of our rural hospitals are on the verge of a real breakthrough in adding physicians to their community, and as a result will improve the occupancy rates and effective

utilization of their hospitals, and of course will increase the number of annual admissions to the hospital. The reward for this success will be severe penalties under S.3191 - as much as 50% penalty on revenue for increased admissions. This is both unjust and unwise in view of the needs of local communities and patients.

5. Utah has 3.06 acute hospital beds per 1,000 population, about the lowest ratio in the country, in contrast to the national average of 4.45. This is well below the recommended national standard set in the capital controls section of the bill of 4 beds per thousand, and accordingly would not prevent needed bed expansion in Utah. However, expansion of hospitals in keeping with the demonstrated need in rapid growth areas of our state would be prohibited by the national occupancy standard set by the bill of 80%. Our state occupancy rate is 74.8%, the national average is 75.0%. Again, despite our excellent record which permits us to deliver hospital care with the smallest investment of capital in the country as measured by beds per 1,000 population, we would be unable to add beds in the state even in areas of critical need. Also, as mentioned previously our hospitals would be prevented from increasing occupancy because of the penalties for increased admissions. It appears that the bill would lock Utah hospitals totally into a no-growth position, leaving us no way to adjust to population growth or even increased admissions caused by medical necessity or emergency.

Aside from the specific inequities of the bill pertaining to Utah hospitals, there are a number of defects of general detriment to all hospitals. These are:

1. The revenue limit would be retroactive for most hospitals; except those with a September 30 fiscal year-end. This is potentially unfair and poor legislative procedure.

2. The revenue limit formula would restrict the rate of growth of hospital expenditures to less than the rate of increase of the Gross National Product. This will in effect not permit hospitals to even keep pace with the inflationary rate of goods and services purchased and will leave no room for coping with improved or expanded medical services, procedures or equipment. Progress and quality under these circumstances must stop and deteriorate. How can either Congress or hospitals accept this?

3. The exception process would require that a hospital have a ratio of current assets to current liabilities in the botton 25% of hospitals covered - failing in liquidity and on the verge of bankruptcy - and stay there before revenue relief could be granted and continued. This is hardly the way to run a business on which people must rely for health care.

4. As mentioned previously in connection with Utah hospitals, the thrust of the bill would be to penalize the efficient hospital everywhere, in contrast to the less efficient, and this is not to suggest that a higher rate large hospital rendering a broad spectrum of services is inefficient. In effect the hospital large or small that has done the best job in cost containment and has peaked in efficiency will have less of an opportunity to adjust to a revenue cap and survive, than an inefficient hospital. This is both unjust and counterproductive to encouraging long-range cost reduction programs.

Despite our strong opposition to S.1391, we are not unmindful of problems faced by those who are sponsoring or underwriting health care for others. Our hospitals do have

concern for the impact of rising hospital costs on governmental health programs, insurance companies and the general public. Utah hospitals have long engaged in programs to promote efficiency and contain costs as mentioned earlier, including management engineering, management training, group purchasing, group collections, data processing, sharing of services and multi-hospital management services and support. We have also fully cooperated in health planning activities to approve and allocate hospital capital expenditures, and PSRO to appropriately review utilization of facilities as to admission and length of stay, and JCAH activities to monitor quality of care. As a result of these activities and commitment by our hospitals, our ratio of beds per 1,000 population is the lowest in the nation, our length of patient stay among the lowest, and our charges per hospital stay much lower than average. These are all solid indications of our concerns about hospital costs and also are very favorable elements to third party payers of hospital bills.

We realize that conditions differ throughout the country and that all areas may not have been effective in addressing all of the problems of operating costs and capital expenditures, although in many areas and in many individual hospitals everywhere these efforts have been outstanding. Accordingly, and as alternatives to S. 1391 we would suggest continuation of several programs which have been created by Congress, and consideration of a different legislative approach to health cost containment. The existing programs which we feel have merit and should be continued are:

1. Professional Standards Review Organizations. From our experiences in Utah in pioneering this activity, we feel that the PSRO has had a beneficial effect in assuring quality of care while at the same time reducing inappropriate admissions and unnecessarily long patient stay in hospitals. Our PSRO monitors these on-site using Medical Doctors and Registered Nurses, and computer profiles. It has been a factor in the low length of stay in Utah hospitals and the comparatively low increase in admissions.

2. Health Systems Agencies. The HSA program is barely underway, but gives much promise in providing effective rational allocation and expansion of hospital capital assets. We are pleased with the calibre of local public officials, health professionals, and community leaders who are active in the HSA movement in Utah, and feel that this local determination of needs is vastly to be preferred to unwieldy national standards.

3. Mandating of state Certificate of Need legislation. This is important for support of HSA activities. Our Association has endorsed such legislation, which was introduced but failed to pass our legislature last year. Interim study is now being given by our legislature and we anticipate that a bill will be introduced and passed next year.

4. Cost and rate disclosure. This is now being done through Medicare and Medicaid cost reports and filings. It is also being done in some areas through state rate review bodies. We feel that such data disclosure should help everyone to better understand the nature of the problems faced by hospitals in attempting to maintain quality care in the face of inflationary pressures and governmental regulations.

There are other legislative alternatives to S. 1391 that should be considered and among those now before Congress are H.R. 7079 introduced by Representative Rogers, and S. 1470 introduced by Senator Talmadge. The elements of alternate legislation which we would suggest - and most of which are embodied in these bills would include:

1. Payments from federal programs to hospitals with incentives for cost effectiveness. This could be done by a classification system such as proposed in H.R. 7079

and S. 1470 and incentives and penalties based on better or poorer performance than average within the classification group.

2. The use of state rate review programs as an alternative to the classification program listed above, utilizing a prospective payment - budget review process. Such state rate review programs should include all classes of purchasers, and assure payment of the full financial requirements of hospitals. The Rogers and Talmadge bills allows for this alternative.

3. The authorization to utilize acute care hospital beds for either short term or long term patients with a simplified reimbursement formula, again with some incentives for such flexible use of otherwise unoccupied beds. We have conducted an experiement on this order in Utah for several years including Medicare and Medicaid patients and recommend its extension to all hospitals with permanent adoption as allowed in S. 1470 and H.R. 7079.

4. Recognition of costs associated with closure or conversion of unneeded hospital beds in hospital payment formulas. Again this is identified by Rep. Rogers and Senator Talmadge in their bills, H.R. 7079, S. 1470.

5. Strengthening of fraud and abuse capabilities and penalties relating to Medicare and Medicaid, basically as outlined by H.R. 3.

6. The use of deductibles and co-insurance to a greater extent in government health programs (and private programs). Such requirement of co-payment by patients - Medicare, Medicaid, or others should reduce demand, particularly in elective or frivolous cases, and save federal dollars as well as impact on hospital cost increase.

7. Authorization to review and eliminate some of the myriad regulations now imposed on hospitals, many of which cost the hospital industry more than they save-particularly when the added cost of the bureaucracy to administer the regulations is included.

In summary, we feel that the Cost Containment Act as embodied in H.R. 6575 and S. 3191 is extremely poor legislation, that is faulty in concept and was hastily drawn. It does not consider and address many of the real reasons for increasing hospital costs such as the ever present general inflationary trends in the economy as a whole, the increasing and expanding scope of medical services available to patients and demanded by them and their doctors, and the tendency of the public to overutilize health services in the absence of disincentives such as deductibles and co-payment for health insurance or federal programs. It also embodies the wrong solution for cost controls by providing incentives to the less efficient hospital and punishing the more efficient, and it provides a no-growth capital expenditure control for much of the country that will be most unacceptable to many local communities and states that have anything but a no-growth population.

Our hospitals are concerned with the impact of increasing health care costs and are willing to consider alternatives to the Cost Containment Act proposals. We have been engaged in cost containment activities for some time and are willing to continue to pursue these. Further, we are willing to consider and support further Congressional cost control proposals that have a studied phased-in approach to cost containment with incentives toward efficiency and considerations for pass through costs largely

created by factors outside of hospital management control. We commend Congress and the sponsors for their foresight and work to develop S. 1470 and H.R. 7079, which appear to more appropriately address the issues than does S. 1391. We hope that further consideration will be given by the sponsors to deductibles and co-insurance and other measures to defuse the high demand for hospital care. And we strongly urge that H.R. 6575 and companion S. 1391 not be favorably reported, or supported.

Sincerely yours,

John R. Walker
Executive Director

JRW/sd

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HENRY G. COE
Executive Vice President

June 20,1977

Stuart Shapiro, M.D.
Subcommittee on Health and Scientific Research
Commttee on Human Resources
U.S. Senate
Washington, D.C. 20510

Dear Dr. Shapiro:

Please accept the enclosed as the formal testimony of the Vermont Hospital Association before the Subcommittee on Health and Scientific Research, Committee on Human Resources, of the United States Senate with respect to the Hospital Cost Control Act of 1977, S. 1391.

Thank you.

Sincerely,

Henry G. Coe

Henry G. Coe

HGC:lb

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Testimony on the Hospital Cost Control Act of 1977, S. 1391, before the Senate Subcommittee on Health and Scientific Research, Committee on Human Resources

Please accept this as testimony from the Vermont Hospital Association to be entered into the public record on the subject of the Hospital Cost Control Act of 1977, S. 1391. The Vermont Hospital Association represents twenty institutional members of whom seventeen are voluntary not-for-profit community hospitals, one not-for-profit psychiatric hospital, one state hospital for the mentally ill, and one Veterans Administration Hospital. All member hospitals are represented on the VHA's Board of Trustees; all the hospitals in the State of Vermont are members of the Vermont Hospital Association.

At a special meeting of the VHA Board of Trustees May 9, 1977, the Vermont Hospital Association adopted the unanimous position of opposition to enactment of the Hospital Cost Control Act of 1977, S. 1391. Our Board felt that such a bill is arbitrary, conceptually weak, ignorant of the reasons for increases in hospital costs, and fails to recognize the fact that a number of controls have recently been put in place and need an opportunity to work and to be evaluated.

S. 1391 is arbitrary in that it imposes a single across-the-board formula upon all of the nation's hospitals, irrespective of differences in size, location, character of service, and age of case mix of the patient population served. The result may be to penalize those hospitals and those regions of the country with records of cost-effectiveness, efficiency, and moderation of increase, while ironically rewarding the inefficient, Inequity is the result if a uniform cap or formula is applied to a hospital's base period, when it may be that that particular hospital's base is relatively low to the rest precisely because it has operated efficiently in the past. For others there will be little incentives to continue to be efficient; the 9% ceiling soon will become the floor.

We recognize, with the sponsors of this bill, that there is a public concern with rising hospital costs. To treat hospitals in isolation, however, is to ignore the complex array of factors which impinge on the hospital as generators of rising costs; market inflation factors which affect all supplies and labor; intensity of service factors such as increased public demand, improved medical technology, increases in supply of medical manpower; third party payment mechanisms which largely insulate the patient from the economic consequence of his demands on the health system; governmental regulations calling for greater safety, security, and quality assurance; such as the Handicapped Persons Act, minimum wage requirements and proposals for increasing the minimum wage, and proposed stringent rules included in the proposed Clinical Laboratory Improvement Act.

The bill before you compares the percent of increase in the total cost of hospital care, an actual dollar figure, with the general rate of inflation, an index of an increase in prices. This index, however, ignores a number of factors, in addition to inflation, which are involved in hospital costs: the addition of new services, additional use of existing services, and the increased intensity of care made possible by technological advances.

The root of the problem of hospital cost increases is in the demand side. Government, through Medicare and Medicaid, and the private sector, often through employer and employee contract negotiations, has promised and assured our citizens of the availability of a wide range of health services. Politicians and employees are unwilling to put the brakes on, to restrict demand through restricting benefits. Costs will not be controlled through the application of revenue caps. Long-term control of costs will only come about when demand for care is controlled. This is appropriately a legislative or executive role of government. The decision should not be abdicated to hospital boards of trustees and administrators, who under limitations of revenue, will be forced to make public policy decisions by cutting back on services or levels of care.

We respectfully request the Committee to recognize the role of existing federal efforts designed to control hospitals costs and to monitor the quality of patient care. Vermont hospitals currently support and participate in health planning mechanisms (PL 93-641), facility and new service reviews (Section 1122 of PL 92-603), utilization review efforts and the Professional Standards Review Organization, as well as prospective systems of budgeting and budget negotiations with Blue Cross, the state's major third party payer. These efforts should be permitted an opportunity to work and an evaluation made of their contribution to cost containment.

Vermont non-profit hospitals have achieved a record of excellent public service to residents of the state over the years. To our knowledge, no Vermonter has ever been denied hospital services for reasons of inability to pay, yet there are no publicly operated general hospitals. Within recent years, hospital mergers, for reasons of increased efficiency, have taken place in Rutland, Barre-Montpelier, Burlington, St. Johnsbury, and now merger negotiations are underway in St. Albans. Vermont hospital facilities are presently quite well distributed throughout the state with a minimum of duplication. Vermont's 4.08 beds per 1000 population as of 1976, according to the Hill-Burton State Plan, compares favorably with 4.4 beds per 1000 nationally, and the 4.0 goal established in S. 1391. By 1983, assuming no new beds are added, Vermont will have 3.79 beds per 1000 population, using projections in the State Plan. In terms of utilization, Vermont hospitals compare favorably with the nation hospitalizing 1100 patient days per 1000 population in 1976 compared to the national average of 1200 (Source: Inter-Study Report to HEW, New Hampshire-Vermont Blue Cross). Vermont hospitals could hardly be said to be "obese," using Secretary Califano's phrase, when 32% of total Vermont health care expenditures are hospital related, as compared to the national figure of nearly 40% used by President Carter. (Source: Vermont Department of Health Report, December, 1974).

Exhibit A (attached) compares Vermont, New England, and the United States hospitals in two categories: cost-per-patient stay, and cost-per-patient day. There was very little significant difference between cost figures for the United States and the State of Vermont. Reporting hospitals in Vermont, however, were approximately 11% under the New England average for cost-per-day.

Considering the relatively high cost of living in New England, it is not surprising that the New England Region has higher than average cost figures for hospital care. It is significant, however, that even with higher utility costs, higher construction expenses, and higher supplies expense, that the hospitals in Vermont have remained competitive with hospitals across the country on a cost basis.

Exhibit B (attached) is an analysis of Inpatient Revenue per patient day for private acute care hospitals in Vermont. Between the fiscal years of 1973 and 1976, the average annual increase for revenue-per-patient-day was 13.5%. The anticipated increase for FY 1977 is 10.9%, and is a demonstration of good intent on the part of the hospitals in Vermont.

Volunteer community boards of trustees and hospital management in Vermont have worked extremely hard in recent years to contain hospital costs and to be prudent and frugal in budgeting for hospital services. We feel our record is good and would encourage a comparison to be made with the cost expenditure and cost increase record of the federal department of Health, Education and Welfare, and with the unit costs of the Veterans Administration Hospitals in this country.

We respectfully suggest to the Committee that it investigate alternatives to the Administration's bill if a long-term workable solution to the public concern of rising health costs is to be found. Among the lines of inquiry might be the following as discussed at a recent meeting of the VHA Board of Trustees.

1. contain public demand for health services through programs of public health education directed at modification of personal behavior and lifestyle and in the appropriate utilization of our health care system. Contain growth of governmental programs offering new health services and extensions of benefits to eligible groups. An executive clearinghouse function similar to B.O.B. A-95 process could be used. Any authorized new program or program extension should carry with it a concomitant assurance of funding. Third party payment programs should be required to have front-end out of pocket deductibles to discourage inappropriate utilization.

2. Eliminate fragmentation of federal and state tax-supported health service programs via mandatory channeling of funds through regional health authorities or health care corporations. Such authorities or corporations would have management responsibility for assuring comprehensive health services are provided to its service area population. Require that governmental health service programs be allocated on a capitation basis.

3. Provide financial incentives for maximum utilization of

hospital beds through Medicare/Medicaid reimbursement flexibility. Payment mechanisms should encourage such concepts as swing-beds, or multiple levels of care in hospitals not now fully utilized.

4. Studies have pointed out that approximately 85% of a hospital's costs are directly or indirectly attributable to the orders of physicians. Therefore, any program which realistically is going to contain hospital costs must likewise be applicable to the physician. VHA has gone on record in support of a state certificate of need bill which covers physicians who intend to acquire specialized diagnostic or therapeutic equipment whose capital cost is $50,000 or more.

5. Long term control of hospital costs will best be achieved through health planning and controls which are focused on capital expenditures, not on the operating budget. VHA finds itself far more ready to support planning and regulatory controls now in place focused on capital expenditures and plant capacity as well as utilization review than it does controls on the internal operating budget of a hospital.

Providing consistent high quality acute health services, available to all members of the public -- irrespective of ability to pay -- on a 24 hour, 365 days of the year basis is a highly complex activity. It is an activity which has been performed extremely well in Vermont, in the nation as a whole, by men and women of good will in a volunteer and professional capacity. To superimpose a bureaucratic blanket on the hospital's ability to meet its essential capital and operating costs is to stifle the hospital's capacity to survive in a voluntary setting.

We respectfully encourage members of the Senate Health Subcommittee of the Committee on Human Resources to move with great caution in considering this bill. We feel strongly that the complexity of the problem of rising health care costs is deserving of legislative considerations which focus on long term measures and root causes such as limiting expectations and putting a brake on the public's demand for care. Stop-gap controls on operating revenues, without attention to a limitation on demand for services, is misdirected, resulting in haphazard consequences to patients and institutions. We encourage your adverse report on S. 1391.

Respectfully submitted,

Henry G. Coe

Henry G. Coe
Secretary
Vermont Hospital Association
Board of Trustees
June 20, 1977

HGC:lb
cc P. Leahy
J. Jeffords
R. Stafford

PS As an example of the concerns faced by an individual Vermont hospital considering S. 1391, we enclose a recent statement made by the chief executive officer of the Rutland Hospital, Rutland, Vermont.

EXHIBIT A

I. Cost Per Patient Stay

	Vermont	Region	US
5/76	$ 891.69	$1059.24	$ 937.71
6/76	960.17	1120.67	973.09
7/76	961.57	1111.77	963.12
8/76	954.04	1143.11	983.11
9/76	994.37	1141.93	1017.52
10/76	987.48	1127.26	1000.54
11/76	1027.36	1203.45	1032.93
12/76	1155.14	1274.35	1047.98
1/77	1064.54	1229.39	1063.07
2/77	1022.24	1221.14	1041.57

II. Cost Per Patient Day

	Vermont	Region	US
5/76	$ 126.84	$148.77	$135.04
6/76	141.41	159.64	141.98
7/76	147.48	161.36	143.09
8/76	138.87	160.10	143.23
9/76	141.85	161.29	146.09
10/76	148.27	157.00	144.04
11/76	141.51	161.32	146.11
12/76	165.02	174.33	157.10
1/77	136.83	153.29	139.38
2/77	136.48	159.21	142.98

Source: HAS Monitor

EXHIBIT B

Analysis of Inpatient Revenue and Patient Days

FY ending	Inpatient Revenue	Patient Days	Inpatient Revenue/Day	% change in revenue/day
1973	52,100,909	513,082	101.55	
1974	57,618,785	492,184	117.07	15.3
1975	67,453,540	506,545	133.16	13.7
1976	77,571,252	522,477	148.47	11.5
1977	84,244,299 *	511,713 *	164.63	10.9

* budgeted, does not include Springfield Hospital

Source: Blue Cross Study completed June 17,1977.

THE RUTLAND HOSPITAL, INC.
RUTLAND • VERMONT • 05701

JOHN P. RICHWAGEN
Executive Vice President

June 10, 1977

I understand that Congress is holding Hearings concerning the Hospital Cost Containment Act of 1977 as is proposed by the Administration. I am writing this letter to express my concerns about this Bill and its probable effect on health care in Rutland. This proposed Bill may do the exact opposite of what is apparently intended, that is, reduce hospital costs. This letter provides information as to Rutland Hospital operating statistics as compared to the average for our size hospital in the country. Also contained is information concerning unusual cost increases that we have experienced recently or expect to experience in the future. Hopefully, this letter will be helpful to you in your examination of this Bill from all perspectives.

Philosophically, I am opposed to this Bill because it imposes arbitrary limitations on hospital revenues when hospitals do not have control over many of their costs. It is unrealistic to control revenues when hospital costs are being increased by governmental changes in law or factors in the market place over which hospitals have no control. It just is not reasonable to impose such a limitation on hospital revenues without consideration of the factors that make up these requirements for additional income.

Secondly, this law is unfair because it applies only to the hospital industry. This Bill is very similar to the Economic Stabilization Act imposed solely upon hospitals in 1974. During 1971, 1972, 1973 and 1974, the Rutland Hospital was going through an expansion program that had already begun in 1969. We were in very bad financial condition because we were unable to raise our revenues to the required amounts to meet our bond indenture requirements. We had issued $7.2 million in revenue bonds and had a requirement to repay approximately $800,000 per year. We survived this difficult period but it worked a number of inequities in terms of wages paid employees and services to the public.

A third reason for opposing this Bill is that it penalizes the cost-effective hospital to a much greater extent than the hospital that has made few attempts to contain its costs. By imposing a 9% limitation on increases in revenues for hospitals, the hospital that has a great deal of "fat" in its financial structure stands to make out fairly well. The hospital which has not raised its revenues in the past few years to the same extent will suffer. I believe Rutland Hospital falls into this category since we have not raised our rates since October 1, 1975. Rutland Hospital may need a rate increase greater than 9% next fiscal year.

I believe it appropriate at this time to inform you of two basic statistics regarding Rutland Hospital and how we compare with other hospitals. First, we subscribe to the Hospital Administrative Services statistical report that is provided by the American Hospital Association. This provides information concerning many cost factors in the hospital and how we compare with state and national groups. I am selecting a group of 304 hospitals across the country of a similar size as the best means of comparison.

The first statistic involves the inpatient cost per patient day. This cost for the six months ending December 31, 1976 is $113.81 at Rutland Hospital and $151.65 for the 304 hospitals in the national group. This figure is $170.94 for a special group of 31 hospitals compared on a national basis.

Another statistic involves the number of fulltime employees per occupied bed. At the Rutland Hospital for the six months ended December 31, 1976, there were 2.88 fulltime employees per patient per day. For the national group of 304 hospitals, there were 3.39 employees per patient per day. For the 31 hospitals compared there are 3.87 employees per patient per day. I believe that this indicates that Rutland Hospital is not only at the medium of all hospitals, but well below it. We also compare very favorably with other hospitals in our state but I have not provided this information because they are much smaller on average and unable to effect the same volume efficiency.

This information should provide insight into the problems that will be faced by hospitals should this Bill be passed. I have been a strong proponent of health planning and certificate of need legislation in the State of Vermont. This one area is where we should concentrate our efforts to improve health care and reduce costs. There is no question that medical technology will tend to increase health costs in the future and we must control it. We must ensure that new machines and new techniques are truly beneficial to the patient and also cost effective. An individual hospital cannot do all of this - much more must be done on a state-wide basis.

Another factor that should be looked at very carefully is the amount of regulation already imposed on hospitals. This is increasing hospital costs. Please look at the number of federal and state laws and other requirements on hospital operations. Many of them are overlapping and conflicting and superimpose on the hospital organization a tremendous amount of requirements for reporting, safety and peer and utilization review. These are not necessarily inappropriate or undesirable. In aggregate, all these good things increase hospital costs tremendously and must be dealt with in a realistic manner.

I would be very happy to take you on a tour of Rutland Hospital when you return to Vermont or provide any further information should you desire. Thank you for your courtesy and time spent in reading this letter!

Sincerely,
THE RUTLAND HOSPITAL, INC.

John P. Richwagen
Executive Vice President

JPR:kmk
Enc:

THE RUTLAND HOSPITAL, INC.

SOME UNUSUAL COST INCREASES RECENTLY EXPERIENCED OR ANTICIPATED OVER WHICH OUR HOSPITAL HAS LITTLE OR NO CONTROL:

1. *Cost increases in foods - due to drought and freezing crops.*

2. *Cost increases in energy - fuel oil and electricity.*

3. *Increase in minimum wage from $2.30/hour to $2.50/hour or more - this will affect all hospital workers, including supervisors because of small differences between wage scales.*

4. *Additional staff required to conduct utilization reviews, peer review and record keeping - 4 fulltime employees (1 Audit Nurse, 2 Utilization Review Nurses and 1 Record Analyst) - this is mandated by federal law.*

5. *Additional staff and costs associated with increased requirements in infection control (1 Electrician and 1 Electronics Technician); and record keeping (2 Clerical Staff in Bussiness Office).*

6. *Building safety codes required by O.S.H.A., N.F.P.A., the State Fire Marshall and Hill Burton have increased our construction and renovation costs considerably.*

7. *General and professional liability insurance costs have risen from approximately $30,000 to $180,000 in three years, despite very few and small judgements against this Hospital.*

8. *One fulltime secretary to maintain records of the Medical Staff that now are required by the Joint Commission on Accreditation of Hospitals. The equivalent of one fulltime person required in Administration for the same purpose.*

No attempt has been made to attach dollar figures to the above cost increases. We are not attempting to prove that these cost increases are unnecessary or undesirable- only that many cost increases are beyond our control on an individual hospital basis and an arbitrary cap on revenues without consideration of cost factors would be illogical and unreasonable. We hope you agree!

WASHINGTON BUSINESS GROUP ON HEALTH

June 9, 1977

The Honorable Edward Kennedy
The United States Senate
c/o Dr. Stuart Shapiro
Room 310
Senate Court
Washington, DC 20510

Dear Senator Kennedy:

I want to express the appreciation of our Group for your thoughtful invitation to participate in your hospital cost containment hearings. Unfortunately, both Mr. Pilliod and I will be in California with Secretary Califano's National Health Insurance Advisory Committee, thus we are unable to accept.

Please be assured that our inability to join you on June 17 in no way signals a lack of interest. We will submit a written statement for your consideration and it has been my pleasure to have frequent meetings with Dr. Shapiro during recent weeks. His openness to, and indeed solicitation of, our position is sincerely appreciated.

The evolution of business involvement in health care and financing issues is easily understood when one sees the costs now being born by employers and employees. The problems are especially frustrating when the cost is compared to the actual amount of health care improvement. We truly believe that this growing, active participation of major employers can have, in fact already has shown, a significant impact upon simultaneously reducing waste and improving quality and access.

Again, thank you and I hope that you, your Committee and Dr. Shapiro will look upon our Group as a resource during the important health deliberations which will continue for the next several years.

Sincerely yours,

Willis B. Goldbeck
Director

WBG/jlc

cc: Charles J. Pilliod, Jr.
Chairman of the Board, Goodyear Tire & Rubber Company
Chairman, The Business Roundtable Task Force on Health

605 PENNSYLVANIA AVENUE, S.E. WASHINGTON, D.C. 20003 (202)547-6700



WASHINGTON BUSINESS GROUP ON HEALTH

The Hospital Cost Containment Act of 1977

S. 1391

Testimony Presented To:

Subcommittee on Health
of the
Senate Committee on Human Resources

June 21, 1977

605 PENNSYLVANIA AVENUE, S.E. WASHINGTON, D.C. 20003 (202)547-6700

A Statement of Concern About Health Care Costs

INTRODUCTION

My name is Willis B. Goldbeck, Director of the Washington Business Group on Health. I appreciate the opportunity to provide this statement on behalf of our membership which, as you can see from the list below, has grown to 145 members. What the list does not show is the simple yet startling fact that these firms provide the health and medical benefits for nearly 30,000,000 employees, retirees and dependents. If one were to add to that total all the millions who receive medical care, from Kaiser, AMI and the pharmaceuticals, or its financing by the insurance carriers, it becomes apparent that employers are a major factor in the provision of medical care for an amazing portion of our population.

As we discuss the legislation under consideration by your committee, it is important to be very clear about who we are -- and who we are not. We are not representing all business. The small and medium sized employers are not members and do not always have the same position on legislation as the very large companies. There is also no claim that these remarks represent the unanimous opinion of our membership. Some companies belong to more than one national organization. The insurance carriers, for example, have already given you their collective views through the Health Insurance Association of America. They participate with the Washington Business Group on Health because they are not only commercial carriers but also large employers. And, while we agree on many points, in the complex world of health care legislation, we feel it would be unrealistic and less than honest not to openly acknowledge disagreement.

Nonetheless, our position does represent a rather remarkable degree of consensus. Every member company had the opportunity to "vote" (via a survey) on the various positions to be developed in our testimony. A 75% majority was the lowest received on any question. In the interest of a complete exchange, we have tried to convey the members' sense of concern as well as our actual policy positions.

The Washington Business Group on Health

AMAX
AMF
ASARCO
Aetna
Allis Chalmers
Alcoa
American Can
American Cyanamid
American Medical International
AT&T
Armco Steel
Armstrong Cork
Atlantic Richfield
Babcock & Wilcox
Becton, Dickinson & Company
Bethlehem Steel
Boeing
Boise Cascade
Bristol Myers
George B. Buck
Budd
Burlington Industries
Burlington Northern
Campbell Soup
Carter Hawley Hale
Caterpillar Tractor
Chrysler
Citibank
Cities Service
Clark Equipment
Coca-Cola
Columbia Gas
Connecticut General
Continental Bank
Continental Group
Continental Oil
Coopers & Lybrand
Corning Glass Works
Deere & Company
Deering Milliken
Dow Chemical USA
Dresser
E.I. duPont
Eastman Kodak
Eaton
Eli Lilly
Equitable
Esmark
Exxon
FMC
Federated Dept. Stores
Firestone
Ford
General Electric
General Foods
General Mills
General Motors
GTE
General Tire & Rubber
GENESCO
Georgia-Pacific
B.F. Goodrich
Goodyear
Greyhound
Gulf Oil
Hanna Mining
Harris Trust & Savings
Heinz, USA
C.T. Hellmuth & Associates
Hercules
Honeywell
Inland Steel
Inmont Corporation
IBM
Internat'l Harvester
Jewel Companies
John Hancock
Johns-Manville
Jones & Laughlin Steel
Kaiser
Kennecott Copper
Koppers
LTV
Libbey-Owens-Ford
3M
Marathon Oil
Marcor
Martin Marietta
Mead
Merck
Metropolitan Life
Mobil Oil
Monsanto
National Steel
Northern Natural Gas
Olin
Owens-Corning Fiberglas
Owens-Illinois
PPG Industries
Pet
Pfizer
Philip Morris
Pitney Bowes
Procter & Gamble
Prudential
Pullman
RCA
R.J. Reynolds Industries
Ralston Purina
Republic Steel
Reynolds Metals
Rockwell International
SCM
St. Regis Paper
Scott Paper
Sears, Roebuck
Shell Oil
Sherwin-Williams
Singer
A.O. Smith
SmithKline
Southern California Edison
Sperry Rand
Std. Oil of California
Std. Oil (Indiana)
Stanley Works
Stauffer Chemical
Sun Company
Sundstrand Chemical
TRW
Tenneco
Texaco
Texas Gas Transmission
Texas Instruments
Travelers
Union Camp
Union Carbide
Union Electric
Union Pacific
Uniroyal
U.S. Steel
Westinghouse Electric
Weyerhaeuser
Whirlpool
Xerox

A SPECIAL REPORT

Submitted with this Statement, for the record, is our recent report to HEW Secretary Joseph A. Califano, Jr:

A Working Paper On:

A Private Sector Perspective On The Problems of Health Care Costs

We believe this paper will be of use to the Members of Congress and their staffs as they seek examples of successful and innovative private sector cost containment efforts.

The Working Paper also contains our basic philosophy on the overall cost problem and its causes. Therefore, we will not repeat those points here.

OUR POLICY POSITIONS

It is a pleasure to commend President Carter, Secretary Califano, their staffs and the Congressional sponsors of S. 1391 for demonstrating leadership in such an emotional and complex issue.

Before addressing the specifics of this legislative proposal, let me make the following four points:

1. Despite our best efforts and strongest desires, there will be no true "quick fix" to the cost issue. It will be a major accomplishment if this Administration can help reverse the present trend. The one thing we cannot afford is great — and false — expectations. A small success in the near future, that really begins an orderly process of cost containment will have far more value than overly dramatic efforts doomed to fall short of expectations.

2. Cost containment must be part of health policy, not only a regulatory switch periodically turned on and off. In truth, we are not talking about temporary controls but phases of a permanent program which will, whatever its design, change the nature of health delivery in the USA. There is nothing wrong with that, per se, but it does make it difficult to analyze the "phase" without being able to see the program for which that phase is designed.

3. As a matter of public policy, it may be appropriate to allow or encourage certain measures which in the short run, increase expenditures. To be justified, such measures would have to support other accepted social policy goals such as:

   1) correcting the maldistribution of physicians
   2) promoting health education and preventive health procedures
   3) increasing access to quality medical care for special subpopulations
   4) obtaining a "return on investment" by enabling the patient to return to work or a least decrease dependency upon an institutional environment.

In these and other instances, current costs will go up in the hope that long-term costs will go down. These also point up the difficulty of finding measures of what constitutes acceptable costs.

There are also non-health public policies which have major impact upon health costs. For example, it is federal policy to encourage hospitals to make major capital expenditures for conversion to solar energy. However, as written, the Cost Containment Act would make no allowance for such an investment. Further, a recently released HEW study showed that $532 million dollars could be saved by good management of hospital energy utilization, and this does not even include major conversions.

A second example is the capital requirements imposed by meeting the regulations in the *Life and Safety Code*. Yet another area is the conflict between reducing health facilities while not wanting to increase unemployment. Additionally, GAO has documented the great cost resulting from the requirement that a hospital not discharge a child treated for lead-based-paint poisoning until the source of the poison is removed from the child's home. Yet, many housing programs have no policy or budget to do the necessary rehabilitation. And, complying with the new regulations concerning access for the handicapped is a current case of federally mandated capital expenditures. There are good public policy reasons, but the results are contrary to the goal of cost containment.

These examples and others, such as an increase in the minimum wage, are offered not to suggest that anything is wrong with them as policies or programs, but to suggest that a part of the cost problem represents a clash of values and existing social policies which cannot be resolved by the proposed health cost controls.

4. The CHAP program, announced at the same time as S. 1391 is viewed by the vast majority of our members as an excellent effort to improve existing programs and allocate our limited health dollars to areas of high need and long lasting, cost effective results.

S. 1391

Summary

Title I:

Our members, by more than 70%, oppose this method of price control. It should be apparent from past history, that most major employers are opposed to all forms of price controls and thus would oppose an arbitrary 9% regulation regardless of the industry to which it was applied.

Further, speaking strictly from the health care perspective, we do not feel Title I is either the most effective or appropriate method of seeking cost reductions.

Title II:

Despite a variety of concerns, which are discussed below, some 92% of our members support a federally imposed capital expenditure control.

Discussion

Title I:

While not implying support for this Title, we do want to comment upon several of its specific provisions so our position will be clear should any elements of the bill become law.

1. The Administration is to be commended for recognizing that any cost control measure must be applied to all payors, not just public programs. We strongly endorse this "across-the-board" provision and will oppose any program which results in cost shifts to the private sector.

2. We also support the concept of waivers for those States which have prospective rate review programs meeting federal criteria. There are some employers who oppose any form of rate setting, but the vast majority feel the need for some regulatory process and want to see it conducted at the State rather than Federal level. The progress made by States such as Maryland, Connecticut and Massachusetts speaks well for the potential of these systems. Further, we

recommend that you consider basing the exemption upon performance criteria so this law will encourage more States to try innovative programs, even voluntary ones, as long as the results are satisfactory. We recognize that this is not a "quick fix" but it will never be an available alternative unless encouraged now.

3. Fostering a change from the current reimbursement system to one based on prospective budgeting is another feature we endorse.

4. And, we would support the exemption for HMO hospitals.

Aside from the price control nature of Title I, there are a number of serious technical problems we feel should be noted:

1. There is no evidence that forcing even the well-managed hospital to write down virtually all its assets, in order to seek an exception, will produce either cost savings or rational, needed growth.

2. There is no coordination between Titles I and II, and the certificate-of-need/Health Planning process.

3. The wage pass-through is far too broadly defined, as it extends well beyond those who are still in need of any "catch-up" to comparable wage levels. The pass-through should be limited to areas and groups whose wages are substandard. And, consideration should be given to changing the term "nonsupervisory" to "nonexempt", which is already defined by the Fair Labor Standards Act.

   Three other points need to be made on the wage issue.

   a) it simply is bad public policy to grant a blanket pass-through without consideration of need, local conditions or the existing labor negotiation process. A responsible pass-through could be designed — and we would endorse it — that would tie the wage level to some commonly accepted indicator.

   b) when nonsupervisory wages go up, especially since that covers a vast majority of the total hospital labor force, wages for supervisory employees are also driven up.

   c) and, it is unrealistic to pass through the wage increase, at whatever level, and exclude the fringe benefit — Social Security increase that automatically follows.

4. There is a basic flaw in a control program that treats those hospitals which are well managed in the same way as those which are not. One of our members succinctly expressed this dilemma:

> "The simplistic premise of Title I that pressures must be applied to get rid of 'inefficiency' and 'fat' in hospitals will discriminate perversely against efficient institutions. The analogy is simple: If fat and slothful people, along with lean and muscular people are both put on a starvation diet, the fat will get thin and the lean will starve — a poor formula for developing a lean or 'efficient' population."

5. It is unclear how the individual payor will know that a specific reimbursement will cause the hospital's annual total increase to exceed 9%. Until this position is clarified, the tax penalty on payors may not be enforceable.

6. To be effective, prospective State rate review must cover government health programs, such as Medicare and Medicaid, as well as the private sector programs.

7. Although there is administrative merit to using the class of purchaser system, this process can hold some hospitals to less than the 9% increase, without regard for need. For example, a hospital with a mix of classes of purchasers may have one above 9% and two below with an average less than 9%. Unless you allow those already below 9% to increase — hardly desirable — the hospital is trapped.

Title II:

We do support the concept of limiting the amount of capital available for expansion. Without some such limit, new investment will automatically keep driving up the cost of care. The proposed limits would serve to force a comparative assessment of the value of each projected expansion within an area. We believe this is very beneficial. One of the major reasons to support the capital limitation is the simple fact that each dollar spent generating a new facility will cause annual operating expenses of $.50 to $1.00. Thus, the major savings due to the capital limitation will be in the avoidance of long-term operating costs.

There are some specific suggestions we would like to offer:

1. The population formula has severe problems that may prove to be anything but cost effective. Three examples:

   a) hospitals, in the Northeast, are generally older than those in the "Sunbelt" and are more in need of modernization regardless of population.

   b) it is the policy of the Carter Administration to encourage revitalization of our older central cities. Housing and community development, transportation and economic development assistance policies are all being turned toward this objective. Yet, the population formula would work to the explicit disadvantage of such areas. Allowing further deterioration of medical facilities can only contribute to a continued exodus from the central cities.

   c) I'm sure it is unintentional, but the current formula may work against the Health System Agencies. Ironically, this will be where the HSAs have been doing the best job. In Akron, Ohio, the HSA reduced $147 million of applications to $85 million in approvals between August '74 and April '77. Of this amount, $20.4 million was for out-patient facilities specifically designed and approved with the goal of reducing the use of more expensive in-patient care. Based on the population formula, approximately $25.5 million would have been available for this HSA during the same period, thereby virtually eliminating all flexibility in the development of new outpatient facilities. If the HSA is allocated funds sufficient only to support basic replacement of obsolescent facilities, they will not have any options to improve the health delivery mix for true long-range cost containment.

   d) related to (c), above, are the image/attitudinal problems created by squeezing the HSAs too tightly. They will never be accepted by the community if they must say "NO" 90% of the time. The key to successful planning is the negotiation/compromise process. If the available funds are too

small, then all parties know the outcome in advance and all incentive to work for the best health-dollar investment is removed. Further, it will quickly become nearly impossible to attract good people into the planning system. Planning by formula is neither good planning nor enticing employment.

2. Our endorsement of Title II does not imply agreement with the $2.5 billion first-year "allocation." I don't know what the right amount may be. But I do know that 50% of last year's total is 50% of something that grew without any rational policy content. 50% of NO logic is still NO logic, albeit a smaller amount! Title II must be accompanied by a major effort to develop a ceiling which is based on accepted, manageable measures of current need.

3. As indicated earlier, we believe those capital expenditures incurred by hospitals as a result of other government regulations should be passed through. At the same time we would recommend a thorough review of the total impact of government regulation upon hospital costs. Much of the current regulation is needed. But the following example shows how ridiculous — and expensive — the situation has become:

> In 1976, hospitals in New York State were regulated by 40 federal, 96 State, 18 county & city, and 10 voluntary health agencies. That is 164 separate agencies. They were regulating 109 areas of hospital operations. Of these, 82 were monitored by 10 or more agencies. (Source: New York State Hospital Association)

4. Concern for quality of care all too frequently gets lost in the dollar-oriented debate over quantity of facilities. We think the two can be combined and offer for your consideration a concept first brought to our attention by Thomas W. Langfitt, M.D., Vice President for Health Affairs, University of Pennsylvania.

> "...whenever a hospital asks for something new, they should be required to identify what they will get rid of. The watchword should be substitution. The size of the hospital and the scale of the operation should remain constant for the foreseeable future and in fact may have to shrink with the continuing shift of services to ambulatory settings outside the hospitals. The emphasis should be on growth by substitution which is growth in quality while size and scale remain the same."

5. The beds-per-thousand and occupancy formulas are good, and reasonable, guidelines which we support. The review and exception process must, however, be extensive, and expeditious. Population shifts and, local conditions of need can change very rapidly and there is no such thing as the perfect arbitrary number. For some communities, a reduction to even 4 beds-per-thousand would leave wasted facilities. Other areas, for their own unique reasons, may really need 5 or even more.

ALTERNATIVES

By opposing Title I, we are not implying either ignorance of or apathy towards the cost issue. Our support for Title II, however guarded, is not a step lightly taken. Most importantly, we believe that, with or without federal controls, alternatives must be pursued. We do not believe that there is any, single, "quick-fix" to the complex cost escalation problem.

Strengthening the health planning process has high priority among the many necessary changes. We have supported P.L. 93-641 and believe that a careful examination of the Health System Agencies will show a close correlation between corporate support and successful planning. When P.L. 93-641 is reconsidered by the Congress, we will speak in favor of strengthening the law. Naturally, our position will be more refined by then, but several recommendations can be made now, that are germane to the cost containment issue.

1. Certificate-of-Need will not be effective unless there is also a recertification process, coupled with strong public disclosure requirements.

2. Decertification and reassignment of function is needed. This carries with it the responsibility to create innovative buy-back and refinancing mechanisms. Medical facilities cannot be the only structures in society which are guaranteed a permanent existance regardless of their usefulness.

3. The certificate-of-need procedure should include all medical and health facilities (home health, ambulatory care, corporate

extended care clinics, leased space, site and facilities acquisition, and all government beds and facilities). At the same time, the planning process must be guarded against inequitable treatment of such "nontraditional" systems as HMO hospitals, proprietary hospitals, health alliances, and hybrids of the current structure.

4. Large capital expenditures for equipment should also be subject to certification, no matter where that equipment is to be located.

5. For the planning process to work, a major effort must be directed at establishing scientifically valid and publicly accepted measures of health and medical outcomes, cost benefit relationships, and medical-hospital standards of risk and efficiency.

6. Credit should be given, during the certification process, for those applications which contain a commitment to nutrition, immunization, hypertension treatment and other health education and lifestyle improvement objectives. Mental health programs should receive special emphasis.

7. The mandatory consumer majority should be retained. But doing so involves a commitment to the time and resources necessary to help educate those who have had little or no prior contact with the health system.

8. The government must fund the HSAs at a reasonable level if they can ever be expected to perform their designated tasks, plus those called for in S. 1391.

9. The national health policy formulation, called for by P.L. 93-641, must be started with full participation by all sectors. It would be reasonable to build upon the work and experience of the NHI Advisory Committee when initiating this new effort.

10. A process of medical technology assessment must be established. Its results should be made available to all health planners and its process made an ongoing part of medical education. This must be designed so as to control access to the marketplace without inhibiting innovation and investment in research.

Health planning, as defined by P.L. 93-641 and its regulations, will not work equally well in all communities, and will experience some failures. But, it is viewed by the major employer-purchasers as a big step in the right direction.

There are many things, other than health planning, which can contribute to our mutual objective of reduced cost escalations.

1. Advance the 1980 Certificate-of-Need requirement, mandated by P.L. 93-641, to 1978 or 1979.

2. The "malpractice crisis" is one of the most expensive and wasteful factors now pushing up the costs of health care. Based upon a formula equitable to both consumers and providers, impose, we would suggest a moratorium on medical injury liability suits until a permanent resolution to this problem can be agreed upon.

3. Establish a second surgical-opinion program for all federal employees and all persons receiving care through any government program.

4. Encourage concurrent utilization review for all classes of patients and for all treatment locations whenever surgery is involved.

5. Increase and improve the HMO program with added emphasis on mental health.

6. Adopt policies to encourage home health care, health education, and increased responsibility of each individual for his or her own health maintenance. This includes working with the Office of Education so health awareness and self-maintenance become integral parts of all levels of education.

7. Regardless of the existing cost containment proposals, encourage prospective budgeting based upon State rate review programs.

8. Address the growing conflict between the need to reduce costs by merger; sharing facilities, equipment and services; and the Federal Trade Commission's current efforts to restrict such activities under the anti-trust statutes.

9. A major concern is the effect that an influx of new physicians and other medical professionals will have upon demand for services, and thus upon costs. Health policy must rationalize the relationship between the number of medical schools actually needed and those being planned or developed.

CONCLUSION

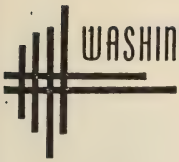
Major employers are acutely aware of the health care cost escalation issue. In unprecedented numbers and with rare speed, employers are becoming directly involved: changing corporate policy and benefit design, accepting new degrees of government involvement and generally becoming direct participants in the search for solutions to the problem.

It has been suggested that "big business" will soon face such great costs that it will simply turn to the government for a full and final escape.

Let me erase that idea. First of all, there is no escape. The largest generators of taxes will always pay the largest share of the cost, regardless of whether the payment mechanism is the current public-private mix or all public. Secondly, we do not believe that the solution, anymore than the problem, lies completely in either the public or private sectors. Problems of this scale require the best of cooperative efforts and while we wish to reaffirm our desire to work with the public sector, we also want to clearly reiterate our commitment to the improvement and strengthening of the private sector's role in health and medical care delivery.

Lastly, one cannot address the health care cost issue without noting its relationship to national health insurance. This is not the place for a lengthy debate on NHI. It does seem appropriate, however, to make clear our position that, whatever form of NHI one may endorse, health care costs must be under control before NHI is fully implemented.

Thank you again for the chance to share our views with you on this very important issue.



TO: The Honorable Joseph Califano
Secretary
Department of Health, Education and Welfare

A Working Paper on

A Private Sector Perspective On The Problems of Health Care Costs

April 1977

605 PENNSYLVANIA AVENUE, S.E. WASHINGTON, D.C. 20003 (202)547-6700

The Goodyear Tire & Rubber Company

Akron, Ohio 44316

CHAIRMAN OF THE BOARD

April 5, 1977

The Honorable Joseph Califano
Secretary
Department of Health, Education and Welfare
Washington, D.C. 20201

Dear Mr. Secretary:

In accordance with the discussion held in your office on March 16th, I am attaching a brief report on the health care cost containment experience of some of the major U.S. employers.

This information has been compiled over the past two weeks since our meeting by the Washington Business Group on Health. The actual work is the result of a series of meetings in New York, Washington and Chicago, supplemented by extensive telephone conversation with more than 70 major employers involved in the hospital cost control issue.

In view of the urgency of the situation, Mr. Goldbeck has updated Mr. Fullerton of your staff on a day to day basis as the work progressed, but I felt you would want this final report for ready reference.

I would hope that the successful experiences enumerated here would assist you in preparing a program of cost containment in hospital care which would be acceptable to all members of society. Direct price controls would only lead to a reduction both in the quality and the availability of services.

Again, speaking for all those in attendance at the March 16th meeting, we enjoyed the opportunity to exchange viewpoints with you and if we or the Washington Business Group on Health can be of further assistance in your work, please call on us.

Sincerely,

TABLE OF CONTENTS

Letter of transmittal from Charles J. Pilliod, Jr.
Foreword, Willis B. Goldbeck . . . . . I - II
Executive Summary. . . . . III - V
Part I : Cost Containment Initiatives, by topic. . . . . 1 - 15
Cost Containment Initiatives, by company. . . . . 16 - 33
Part II : Hospital Cost Control . . . . . 34 - 39
Appendix . . . . . A 1 - 20
Resources. . . . . R 1

* * * * * * * * * * * * *

INDEX

Part I

A. areas of broad concern:

- health planning
- alternative delivery systems
- health education
- quality assurance
- prospective state rate review

B. administrative controls:

C. benefit program changes and additions

- second surgical opinions
- pre-admission testing
- home health care
- co-insurance and deductibles
- health screening
- ambulatory care and surgical centers
- special illness programs
  - . drug dependency
  - . alcoholism
  - . mental health
  - . dental care
  - . vision care

INDEX (continued)

Part II

Standard Oil of California. 16
Allied Chemical 17
Mobil Oil 17
FMC 18
General Mills 19
Greyhound 20
duPont. 20
TRW 20
Goodyear. 21
Occidental Life 21
SmithKline. 21
Connecticut General 23
Employers Insurance of Wausau 23
Equitable Life Assurance Society. 23
Ford Motor Company 24
General Motors. 24
R.J. Reynolds 27
Deere & Company 27
PPG 27
Alcoa 28
Corning Glass 29
IBM 29
Rockwell International 30
Continental Bank. 31
George B. Buck. 32
Procter & Gamble. 33

APPENDIX

Mobil Oil. . . . . A - 1
Goodyear Tire & Rubber . . . . . A - 2-3
Employers Insurance of Wausau. . . . . A - 4-7
Ford (General Motors & Chrysler) . . . . . A - 8-10
Alcoa. . . . . A - 11-13
San Joaquin Medical . . . . . A - 14
Michigan Blue Cross & Blue Shield. . . . . A - 15-20

WASHINGTON BUSINESS GROUP ON HEALTH

FOREWORD

This report represents the second phase of an on-going effort to have major employers and the Carter Administration work cooperatively in pursuit of an improved health care system for the United States.

Phase one was a lengthy and wide ranging discussion between Secretary Califano and a group of business leaders. That meeting established the mutuality of concern and interests that is an essential foundation for future cooperative efforts. At the conclusion of that meeting, it was agreed that we would, by early April, prepare a report covering two major topics:

I - non-governmental, or private-public, efforts to improve the health delivery system while simultaneously reducing the rate of health care cost escalation.

II - the Administration's hospital cost control proposal.

In neither case, do we view this submission as our final contribution.

The efforts described in Part I are, by their very definition, on-going and the quantity of these efforts is growing at a pace which far surpasses our capacity to report on it. This is good. And we are preparing to establish, within the Washington Business Group on Health, a program to make available to HEW and the business community a Quarterly Progress Report.

On the more controversial matter of hospital cost controls, we have based our remarks on the Administration's proposal as outlined to us by Secretary Califano on March 16. We know the proposal is still being refined and we anticipate being full participants in the public and Congressional debate which will follow the enunciation of the proposal's final content.

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I began by saying we seek an improved health care system. So saying does not in any way deny the remarkable achievements of our existing medical care system. However, as major employers paying tens of billions of dollars annually for health and medical care, and as individual citizens, it is not difficult to see that major improvements should and can be accomplished. Controlling the cost problem is but one of many tasks ahead. And just as surely as we cannot create major new national health initiatives without first controlling the costs, so too we cannot have a health system of adequate quality and public acceptance if the whole focus is on cost control. Therein lies the challenge.

A challenge we believe can only be met by the strongest possible private-public cooperative effort. We hope this Working Paper will make a small contribution.

Willis B. Goldbeck
Director

EXECUTIVE SUMMARY

The theme of this Working Paper is a simple one: *the rapidly growing quantity and quality of private and private-public efforts to contain health care costs without reduced quality of care is evidence that methods other than price controls can effectively achieve our mutual objectives.*

We have tried to take a broad view of this most stressing and complex issue. Stressing because it represents a classic confrontation between good values competing for scarce resources. Complex because not only is every American affected emotionally and financially as well as medically, but also because we are forced to attempt the rationalization of a system of health care the historical premise of which is that it not be a single system.

Please recognize that these comments and suggestions are not presented as solutions but rather as starting points in a discussion which will, inevitably, be of long duration. Further, we make no claim that these are original ideas. They simply represent what we feel at this time is an accurate reflection of positions most major employers can endorse.

We endorse your objectives and especially the open, forthright manner in which you have presented your proposal for review and comment.

To reiterate, we cannot support direct price controls. We take that position not only because we are philosophically opposed, but also because there is ample evidence that such programs do not work, no matter how carefully designed.

It must also be recognized that a limitation on the prices hospitals can charge, without an adjustment for the costs they will incur, is unrealistic, and can only result in reduced services and lowered quality of care. Varying with the community, hospital costs are 55 to 65% labor oriented and the Administration has already gone on record as being against wage controls without which a 9-10% cap would automatically fail.

True cost containment cannot be achieved without a permanent national-local mechanism. This implies a major public-private commitment to health planning. In this connection, we respect the leadership you have already provided causing a long overdue, in-depth focus on the cost issue. We believe it would

be appropriate and very helpful for the Department to issue clear, strong, yet achievable, guideline objectives for total inpatient revenue and capital increases. This would strengthen the planning process and would contribute to a more cohesive private-public effort. Further, such a process would, in short time, provide the data necessary to make future cost containment policy objectives on an empirical basis.

In health planning, while notable progress has been made in some localities, it must be admitted, overall progress to date has been spotty. Many of the Health System Agencies are new and inadequately funded. The process is in place however, and in our opinion, offers an excellent structure for an early start on a well designed cost containment program. We recommend that you consider the regulatory and legislative mechanisms to handle some of the recognized deficiencies and bring about improvements in the planning process. Some of the items to be considered are enumerated in this Working Paper.

We also encourage further development of Concurrent Utilization Review programs, and statewide prospective rate review where acceptability is based on technical and performance criteria thus allowing the programs to be either mandatory or voluntary.

One of our serious problems is that there exist few adequate or accepted or followed medical-legal standards by which quality and appropriateness of care can be measured. This problem is reflected in the rise of malpractice premiums which in turn are reflected in health care cost increases and reduced services. An even more deleterious result is that we are left with no sound basis upon which to make cost-benefit trade offs within the health planning process.

It is also recommended that a cost containment program include steps to promote long range health improvements rather than just concentrating on the acute medical care system. Substantial attention should be devoted to such preventive health topics as:

A. nutrition
B. immunization
C. hypertension (identification & maintenance)

The further encouragement of Health Maintenance Organizations (HMOs), a revision of the Medicare-Medicaid leasing regulations to avoid repeated "purchase" of the same equipment and furtherance of home health care in general and specifically in the dialysis program will all result in significant reduction of waste.

Cost savings in the billions can be achieved through resolution of the malpractice insurance problem. Many approaches are being studied and we believe it has become a problem of sufficient magnitude to warrant federal intervention, at least for the short-term.

Uniform reimbursement by all payors, government and private, should be instituted. Unless the government pays its fair share, it only shifts those unpaid costs to the private consumer.
Locally administered and professionally conducted monitoring of care and cost (the PSRO concept, if not the program) should be strengthened and extended to private and employer-based health programs.

We need to develop cooperative government-labor-management efforts to design and accept an insurance payment system in which all who can pay do pay a fair share. The total coverage, third-party payor concept, whether that payor is government or private insurance is simply too strong an incentive for over-utilization. We believe incentives can be designed to make the movement away from first-dollar coverage acceptable while achieving the best balance between under- and over-utilization in the pursuit of cost-effective care.

It is our belief that the examples of successful progress contained in this Working Paper, and the recommendations provided above, combine to establish that there really are viable alternatives to the price control process which is contrary to all of our desires, including the principles publicly enunciated by the President.

We welcome this opportunity to share these thoughts with you and are prepared, through the Washington Business Group on Health, to devote the time and resources to work with you in pursuit of an improved and less wasteful system of assuring all our citizens satisfactory medical care at reasonable prices.

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PART I

COST CONTAINMENT INITIATIVES

In response to the Secretary's request for information, we conducted a fast data collection project by mailgram, phone, letter and workshop. The result was an outpouring of data, experiences and opinion. Separately, this information reflects rather small gains by individual employers. However, when viewed collectively, the information reflects a series of very healthy trends of considerable significance:

A. employer involvement and commitment is increasing rapidly and is doing so in terms of:

   1. numbers of employers
   2. knowledge of corporate staffs
   3. leadership by Chief Executive Officers
   4. dollars invested for health care improvements
   5. respect from the health industry

B. broad scale experimentation has become acceptable.

C. knowledge of and concern for health care, rather than just medical care, is increasing.

D. it is possible to reduce waste, lessen utilization, save money and in so doing provide better health benefits for the employee.

E. management and labor can work cooperatively on most if not all of the initiatives currently in progress.

F. government program initiatives such as health planning, HMOs & PSRO are really just starting and are receiving considerable employer support. In fact, where these programs appear successful, employer support has frequently been an essential factor. There is not unanimity in the employer community, but that is not a serious problem since the array of programs makes it possible for the employers to place their efforts in the direction most suited for their own needs and philosophy.

G. two prime problem areas emerge as difficult for employer involvement to foster significant change:

   1. the very large metropolitan areas where no single employer or insurance carrier has a large enough share of the medical market to really be a leader.

   2. remote rural areas

   These problem areas point to the need for the next generation of employer involvement: aggregation of effort with other employers and local governments.

H. However, for the rest of the country it is possible to look at the results from only a few years of employer involvment and see amazing progress...progress sufficient to suggest that the best government policy would be one of strengthening existing programs and supporting the private sector rather than taking any federal action which would reduce or eliminate the incentives for serious local, private efforts.

We have organized the material in three sections:

A. by program...to present the key issues, pros & cons as expressed by the employers who are directly involved.

B. by company...direct quote and our own summary of the materials collected and discussions held.

C. (in the Appendix) by case study...several of the more extensive and informative submissions are presented in full.

Three caveats need to be considered:

A. new material is arriving daily and we are just starting to design an orderly process to facilitate regular reporting of these initiatives.

B. in many cases, the employers reported that there has been no significant change in the few months since their submission, through the Washington Business Group on Health, to the Council on Wage and Price Stability. We felt it would be an unnecessary contribution to the paper explosion to reproduce that material in this report.

C. to make this report available on the Secretary's time schedule, we have not sent it to all the members for prior review. Therefore, the interpretations, unless in quotations, are my own responsibility. The full membership will have the opportunity to participate in the next report's development and we will clearly identify any errors or problems which are brought to our attention.

There is no easy or fast road to a "cost contained" health system. Nonetheless, one of our members expressed the essential spirit of the current efforts:

> "Experience suggests that efficient use of health dollars is just as habit-forming as wasteful practices have been, and spills over into non-hospital care."

PART I: Cost Containment Initiatives by Topic

The entire issue of health care cost containment is fraught with definitional problems. First of all, the current cost problem primarily concerns medical care, not health. Secondly, nearly all parties are agreed that the best hope is to lessen the rate of cost escalation rather than affecting any absolute reduction of current costs. Third, rarely can any single source, public or private, take full credit for a major "cost containment" success. And, the entire national effort suffers from the political paranoia which translates economic pressures into a search for simple and quick solutions.

We view cost containment at two levels:

A. those things which can have some immediate or relatively short term impact.

B. those more difficult, long-term, efforts which are essential if the problem is ever to be resolved.

Ultimately it will be the convergence of a multiplicity of short-term efforts with the long-term development of a true health system based upon an evolving health policy that will produce, on the national scale, adequate health care for all, at a publicly understood and acceptable cost.

The material which follows reflects the discussion we recently conducted with small groups of business leaders and the written submissions received from many of our member companies.

The topics are divided into three categories:

A: areas of broad concern which can have lasting, system changing impact

B: administrative controls

C: benefit program changes and additions

Although neither ERISA nor OSHA come within the scope of the Working Paper, it is important to note the extensive impact both do and will have upon health care and its costs. It is not without significance that a survey we conducted in late 1976 identified OSHA requirements as the largest single impetus for corporate multiphasic health testing programs.

A: *areas of broad concern*

Health Planning

While a vote would not be unanimous, business can be characterized as being very supportive of the planning process. Through the Health System Agencies and the other public bodies established by P.L. 93-641, the major employer/purchaser is finding new access to direct involvement in the health delivery system. This, in turn, is stimulating an increased degree of corporate commitment to become truly informed consumers.

Many of us really believe that planning represents one of, if not the last chance for the private sector to work with government on health.

Employers need to make their voice heard working with providers. The HSAs provide a mechanism to do this at the local level which is exactly the level most of us feel to be most appropriate for health delivery system decision-making.

The Planning Act calls for the development of a National Health Policy. And even if no single policy is ever articulated, the process must begin, for what we have now is policy by default.

Planning, it should be clearly stated, will neither solve all our problems nor will it provide a "quick fix" to the health care cost problem. It is, however, an essential building block for both policy and cost containment, especially if the latter is ever to be accomplished without a major reduction in quality of care.

Planning must be viewed as a long term, evolutionary process. Seen in any other way, it will be doomed to that government graveyard of false expectations.

Planning ought to be, and can be, a bridge between the business and health communities: A far stronger and more informed bridge than the mystique and near reverence which were the traditional roots of the employers' unquestioning support for the provider professions.

When the Administration and Congress begin to seriously consider changes to P.L. 93-641, there are some suggested improvements which reflect the experience and interests of many major employers:

1. certificate of need will not be sufficiently dynamic unless there is also a recertification process. However, we are concerned this orientation may place inequitable burdens upon the investor-owned hospitals without proper regard for the efficiencies they may represent.

2. de-certification and facility conversion must also be part of the process. And this carries with it the responsibility to create innovative buy-back and refinancing mechanisms. Medical facilities cannot be the only structures in society which are guaranteed a permanent existance regardless of their usefulness.

3. the certificate of need procedure should include all medical and health facilities (home health, ambulatory care, corporate extended care clinics, leased space, site and facilities acquisition, etc.).

4. large capital expenditures for equipment should also be subject to certification, no matter where they are located.

5. for the planning process to work, major investments of public and private money must be directed at establishing & enforcing scientifically valid and publicly accepted measures of health and medical outcomes, cost-benefit relationships and medical-hospital standards of risk and efficiency.

6. incentive formulas should be developed to encourage nutrition, immunization, hypertension treatment and other health education and promotion objectives.

7. all federal, state and local government hospital beds and health facilities should be included in the formulas used by HSAs to determine need.

8. the government must fund the HSAs at a reasonable level if they can ever be expected to perform their designated tasks.

9. the health policy formulation, called for by P.L. 93-641, must get underway with full participation by all sectors.

Health planning, as defined by P.L. 93-641 and its regulations, will not work equally well in all communities, and will experience some failures. But, it is viewed by the major employer-purchasers as a big step in the right direction. And those who would oppose this planning legislation in a vain search for yesterday should keep in mind that the alternative is not less regulation but more stringent controls.

Corporate support for the HSAs can be a vital factor in their fiscal solvency and management capacity. This is especially significant

while the HSAs remain underfunded by the government. The HSAs, in turn, are a positive force to bring the traditionally separate and opposing factions of the community together for a common objective. One example, just being established, is the Maine Business Group on Health. It will work in conjunction with but be totally independent from the Maine HSA.

Alternative Delivery Systems

Some employers have had bad experiences with HMO's and feel the concept can never succeed without on-going federal support. Most employers, however, have had satisfactory experiences and are supportive of the pre-paid concept as an alternative delivery system.

Generally, the HMOs initially cost more per employee than the indemnity plans...but that shifts after the first few years.

The more active involvement employers have with an HMO, the more they seem to be satisfied with HMO performance.

HMOs were oversold. Predictably, the result is false expectations and disappointment. HMOs are not the answer nor are they suited for everyone but employer interest is growing, rather than declining. And for some, HMOs are one method of gaining near total control over the delivery of health care to employees and dependents. With indemnity plan premiums soaring and self-insurance increasing, the HMO concept becomes a more attractive option.

A major problem is surfacing that will cause increasing employer reluctance to support HMOs. That is the explosion of state laws which not only conflict with one another but also cause conflict and duplication with the Federal HMO law and its requirements.

A major problem when talking of alternative delivery systems has been the paucity of options. HMOs have received all the attention and money, and not necessarily to even their own benefit. There is growing interest in Dr. Ellwood's Health Alliance concept, but no real experience.

Dr. Richard Egdahl of Boston University has been working on the development of Industry Sponsored Health Plans which would build upon the extensive investment in existing corporate medical facilities and personnel. Gillette, in the Boston area is a prime example.

Health Education

One of the most important, yet difficult, long-range efforts must be in health education. The difficulty lies not only in the obvious complexity of trying to change the living and medical care consuming habits of the public, but also in the fact that it is very hard to obtain measurable results. The heart of health education is information. Before there can be meaningful measurement, that information must be received and acted upon. Since there is no way to control all the individual habits involved, health education has been left to devise other methods of "proving" its value.

It is clear that even the most successful educational program needs to be ongoing and to have the cooperation of all affected sectors. Consider the federal High Blood Pressure Education Program. They have had remarkable success in raising the proportion of hypertensives who are aware of their illness. Nonetheless, the proportion of aware hypertensives who actually receive and maintain treatment is still very low. To add the follow-up that is essential for education to have meaningful impact, employers must become actively involved; providers have to change attitudes; financing mechanisms must be shaped to become incentives for timely and appropriate care rather than impediments; and the educational program must be as varied and ongoing as possible.

There is virtually no end to the topics which can come under the health education heading. Many of these will be separately discussed elsewhere in this Working Paper. Of importance to note here is growth and diversification of the health education effort by many companies. The days of the periodic bulletin for employees is fast being replaced by expensive and extensive, multi-media communication techniques. Classes, both on and off work hours, are increasing. Concern for off-the-job health problems has surfaced as the largest growing element of employee health education. Involvement of dependents is also growing as the relationships between health and other benefits costs become increasingly apparent.

It was corporations, which, in conjunction with the National Health Council, launched the National Center for Health Education.

The Washington Business Group on Health is now designing a special program to create a communications and evaluation center for corporate health education programs.

Quality Assurance

Employers are increasingly aware of the value of the professional standards review concept. The PSRO program has not been as effective as had been anticipated, but the concept is valid. In the next year, more employers will be seeking an extension of the PSRO review to private sector patients. In this connection, Foundations for Medical Care are having a resurgence of employer support.

Utilization review, especially on a concurrent basis, can also show positive, and fast results. For example, Michigan Blue Cross/Blue Shield began a utilization review program in 1976. In just the first six months, the results were:

- a 2% reduction in admissions per 1,000
- a 5% reduction in patient days per 1,000
- a 4.93% reduction in average length of stay

The Washington Business Group on Health, with leadership from the Health Insurance Association of America, has encouraged an experimental private sector PSRO program in Southern California.

Prospective State Rate Review

State programs are a very positive development and warrant support. Evidence to date shows great diversity of results and may indicate that voluntary programs have a potential positive impact equal to or exceeding the legislatively mandated programs. An Ad Hoc committee of insurers, employers, providers and State officials will soon be making recommendations on the future direction of the prospective rate review movement.

B: *administrative controls*

Historically, employers have employed relatively few people in health benefits administration; there has been rather unquestioning acceptance of the insurance carrier and medical professional; and data upon which policy decisions could be made was minimal. Today, all this is changing.

- more people are being hired to work in health benefits — and they are frequently young professionals with more knowledge of health issues than the company's products.
- self-insurance has proven financially attractive to many and also increased the incentive for direct intervention in the local health scene.
- data is rapidly being accumulated resulting in an employer-consumer who can meet the provider on equal terms.

These changes are reflected in a variety of cost control efforts:

- contracts for peer review
- strengthened coordination of benefit procedures
- where possible, a return to co-insurance and deductibles based on the philosophy that some financial participation is essential if over-utilization is ever to be reduced.
- regionalization of claims administration
- claims cost control procedures are being strengthened and now more frequently involve verification that all procedures were actually performed. This implies being willing to press charges where evidence of fraud exists. Most employers feel it will be essential for the private sector to initiate anti-fraud and abuse measures comparable to those about to be imposed on the Medicare and Medicaid programs. Otherwise, there is no reason to assume that the private sector won't be subject to "spillover fraud" in close proportion to the degree of success the government has in reducing fraud in its own programs. Patient direct involvement in the review of claims can be a major element of fraud detection and prevention and has the added benefit of educating the patient-employee.

- changing reimbursement rules to encourage the use of paramedical personnel.

- participation in prescription drug programs which enable non-emergency drugs to be obtained at discount prices by use of mail-order or direct cash incentive programs.

- cost control committees are being formed in many companies as a new indication of awareness that the health care cost issue does impact upon nearly all benefits and all aspects of the corporate financial condition. This is a very important step in elevating concern for the health care problems to a level where coordinated and sustained action can be taken.

- uniform reporting by hospitals would be a positive development aiding those employers which are most actively involved with providers. However, we do not find much demand for uniform accounting, with most employers feeling that this will just result in otherwise unnecessary administrative costs which will be passed on to the major purchasers.

C: *benefit program changes and additions:*

Few employers would deny that the piecemeal development of their own benefit programs, with the trend toward 100% employer payment, has been detrimental to all cost containment efforts. In the past year there has been a rash of efforts to change benefit plan designs to inculcate more cost consciousness while changing the economic incentives which had previously caused over-utilization of the most expensive facilities.

1. 2nd Surgical Opinion

Probably the fastest growing cost containment measure, second (and third) surgical opinion programs are gaining acceptance far beyond their proven value. There simply has been no program which has conducted the many years of follow-up evaluation needed to scientifically measure the medical and economic results of delayed surgery. In general, employers can present this program as a real

health benefit since the employee/patient gets, at no cost, a second professional opinion can be obtained. . . . As with many other cost stimulated measures, the real benefit may be the development of increasingly educated consumers.

Another problem with the program is the absence of known standard criteria to assist the patient in selecting among conflicting opinions.

2. Pre-Admissions Testing

This is a process rapidly gaining favor among employers. Not only does it catch many abuses, it also contributes to a more aware consumer of the health benefits. A problem arises when the hospital insists on redoing all the tests if there is an admission.

3. Home Health Care

Benefit plans are being changed to use reimbursement as inducement for home health care rather than long in-hospital treatment. There is still some reluctance to pay for "custodial" care which seems endless as well as outside the intended scope of medical benefits. But, there is no denying the increasing evidence that the home setting with often minimal support has, as one company said, "numerous therapeutic advantages and has the potential to reduce, significantly, the total cost of an illness." It has been suggested that the home health benefit needs to be tied to the hospital utilization review program for a realistically controlled "full service benefit."

4. Co-Insurance & Deductibles

The trend toward 100% employer paid coverage seems to be bending, if not broken. For some companies it may be too late. But we tend to forget that only 25-26% of the nation's workforce is unionized and only some 40% of those employees have 100% employer paid health insurance. Therefore, the argument that it is too late "to go back" is simply not valid for most employers.

Today's trend is to gain employee awareness of the need to be a prudent consumer of whatever health benefit is applied. In no example that we collected, was the deductible or co-insurance set at a level that would serve as a deterrent to needed medical care. The sole purpose is to provide an economic incentive for both the patient and provider to consider cost as one of the appropriate factors in making decisions about what type of treatment to purchase/sell.

5. Screening

The validity of health screening programs has not been fully proven. However, especially where selectively applied, the concept of early detection is very attractive and appears cost effective. OSHA regulations have been a great stimulus to the development and use of computerized screening mechanisms. This is one area where an employer has to make a substantial and ongoing investment to gain positive results. Successful screening programs cause added costs for follow-up treatment. Problems exist in gaining the acceptance of test results by the community physician to whom the employees are referred. The presence of extensive insurance is an incentive for repeating tests already adequately documented at the work setting. In sum, it may be that screenings' greatest value, other than the relatively rare instance of early detection of correctable medical problems, is the sense of health awareness the testing process can instill in the participants.

6. Ambulatory Care and Surgical Centers

Nearly all employers recognize that the economic incentives in their health plans have encouraged unnecessary use of the hospital. To correct this, benefit designs are being changed to encourage the use of ambulatory care and freestanding surgical care facilities. The proportion of reimbursement is the primary lever. Requirements which called for prior-hospitalization are being lessened or removed. A potential problem will be controlling over-utilization of thesefacilities if they are totally excluded from whatever controls may be imposed upon hospitals.

7. Special Illness Programs

Drug dependency, alcoholism and special mental health programs are flourishing. Initiated for a variety of reasons, these programs represent an increasing awareness that appropriate mental health benefits can have large and long-term savings in decreased use of medical care for psychologically induced physical problems.

Dental and vision care programs are two of the most rapidly growing new benefits. However, both appear to show very positive medical and cost benefit results when reimbursement creates an incentive for preventive care - early detection.

Physical fitness programs would also fall into this category and become increasingly significant as the employment of the handicapped becomes more commonplace.

Conclusion

Over utilization is not good for one's health...or so might be the theme of this section of the Working Paper.

While the Administration seeks to quickly lessen the rate of health care cost escalation, the major employer/consumers are implementing a range of waste reducing and incentive altering mechanisms. Separately, they are of questionable impact. Together, they form the advance guard of a new private sector health system which shows every bit as much promise of success as any contemplated government programs.

One aspect of this entire issue which has not received adequate attention is the relationship between the rise in health care costs and the decrease in available capital to be applied to other social goals. The Administration's employment objectives cannot be achieved without an increase in capital formation in the private sector. When we get reports of major employers whose health benefit costs were, in 1976, twice the corporate retained earnings, the problem takes on a new dimension.

This problem is all the more acute when one considers that the largest gains to be made in health status depend on the environment and our personal

lifestyle. It is safe to conclude that unemployment can only have a deleterious effect upon health as well as the cost we all must pay for health care.

In the section which follows, and in the Appendix, specific examples of employer programs are discussed and demonstrate the broad spectrum of private sector activity which is the best base, we feel, upon which lasting cost containment can be built.

PART I: Description of Employer Initiatives by Company

1. *Standard Oil of California*

a) Accepted the recommendation of their carrier, Equitable, to recognize charges rendered by free standing surgical facilities to "be the same as if they had been rendered by a legally constituted and operated hospital."

b) Restructured the psychiatric treatment benefit in their medical plan to provide a reimbursement incentive for out-patient care.

c) Recognizing the psychiatric treatment, especially in cases where long-term therapy is needed, is not always suited for either in or out patient care, an "in-residence" program has been established.

"Special Health Services is concerned with 'long-term therapy' under the revised Company Medical Plan. We are having no problem with the 40 hours under traditional one-hour visits. However—

"We are working with cases that, in our judgement, are not sick enough for full, in-patient therapy but too sick for 'an hour here and an hour there' therapy (out-patient). Instead of putting these cases in a psychiatric hospital at a base price of $110/day (for up to 60 days per year), we're getting excellent results by one of two alternates, i.e.,

1. Having the patient 'in residence' at night, but going to the job during the work day, or
2. Having the patient 'in residence' during the day, but returning home at night to prevent complete severances from family environment and responsibility.

"Either of these treatment methods may be handled at charges approximating one-half of the full rate. In addition, 'sick' time is saved in the case of Type 1 (above) cases."

d) Coordination of benefits: While not a new initiative, COB does have a significant economic impact. The figures below are the savings which resulted from COB:

1973 -	$18,671,000
1974	22,633,000
1975	32,311,000

Equitable estimated in 1976 "it is likely that the aggregate savings (by COB) from all third party payors is approaching $1 billion a year."

e) Standard Oil has developed a Health Evaluation Program which is phased-in according to the age and health status of the employee.
"Health Evaluations will be done during the year an employee reaches the following ages: 25, 30, 35, 38, 41, 44, 47, 50, 52, 54, 56, 58, 60, then annually until retirement.

95-195 O - 77 - pt. 2 - 58

Standard Oil (continued)

"The Health Evaluation Program will include the following:

Medical History

Height, Weight

Titmus (visual exam)

Pulmonary Function

MetPath #161 - Blood Profile----------

albumin	iron
A/G ratio	lipid, total
alk. phosphatase	LDH
bilirubin, total	phosphorus
bilirubin direct	potassium
blood urea nitrogen	protein, total
BUN/creat ratio	sodium
calcium	SGOT
chloride	SGPT
cholesterol	T4 Thyroxine
creatinine	triglycerides
G-glutamyl trans	uric acid
glucose	CBC

Urinalysis - Multistix / Microscopic

#162 - Pap Smear + #161

#163 - Blood Profile without urinalysis

Chest x-ray

EKG

Physical Examination

"At the following ages, these tests will be offered in addition to the above:

41, 50, 56	44, 52, 58	47, 54
Sigmoidoscopy (men)	EKG/Treadmill	Barium enema
Xero mammogram (women)	(if not contra indicated)	

60 and annually until retirement - Basic Health Evaluation plus one of the following procedures, if indicated:

Sigmoidoscopy, Xero mammogram, or Barium enema

"When results are ready, employee is given another appointment for discussion of findings by the examining doctor."

2. *Allied Chemical*

"On January 1, 1977 Allied Chemical amended its group medical contract covering approximately 11,000 U.S. salaried employees to include the following additional benefits:

1. we increased the annual per person allowance for outpatient diagnostic and laboratory services from $100 to $150
2. we added an 'Extended Care Facility" rider to our Blue Cross hospital contract.

"These changes were made in order to further encourage the use of less expensive outpatient facilities and, hopefully, to reduce the duration of confinements in conventional-type hospitals.

"We also extended a dental plan to our salaried employees effective July 1, 1977 providing a broad range of benefits, especially in the areas of diagnostic and preventive-type care."

3. *Mobil Oil*

"a) Recently we have announced an original concept of a Contribution Bonus which serves as an additional incentive to employees to hold down medical costs. This bonus, which is the difference, if any, between the maximum Company contribution and the cost of the plan (up to the maximum Company contribution), is paid in a cash amount to the employee at year-end. The concept should become an effective communications tool to focus attention on medical plan cost containment measures, since annual cost savings will result in direct 'in-pocket' benefits to employees.

"b) Deductibles and co-insurance features have been retained. For example, deductibles for extended benefits range from $50 to $200 per person per year depending on salary.

"c) Ten different experience units are used to control costs by reflecting local conditions rather than utilizing one nationwide rate.

"d) Significant savings are being realized as we have become fully self-insured under Section 501(c)(9) of the Internal Revenue Code.

"e) Plan administration was simplified by eliminating the numerous combinations between Hospital, Surgical, and Extended coverage. Our coverage is now either full personal coverage or full family coverage.

"f) Measures currently under active study for additional reimbursement:

1) Ambulatory Surgical Care
2) Second Surgical Opinion
3) Home Health Care
4) Treatment In Extended Care Facilities
5) Treatment in Alcoholism and Drug Rehabilitation Facilities
6) Fully Paid Pre-Admission Testing"

See Appendix for further discussion of the Contribution Bonus plan.

4. *FMC*

"Since 1974, FMC health care costs have increased as given below:

1974 - 1975	1975 - 1976
37.2%	32%

"Although, some portion of this increase is attributable to improved health care benefits, the overwhelming portion is due to higher hospitalization costs, medical service increases, rise in physician fees, and greater employee utilization.

"We have taken some important steps to control health care costs and three of these are given below:

"Financial Control - Each FMC location now has full responsibility to closely monitor and control their own medical expenses. Monthly charges based on individual claim experience rather than pooling arrangements will require closer scrutiny of claims. In the past, the ability to review claims on a regular basis was not available. This step will result in better cost control, particularly in terms of local variances due to hospital and physician services.

"Surgical Centers - The use of surgical centers for minor surgery as an alternative to hospitalization has been approved and is being

FMC (continued)

strongly encouraged throughout FMC. Although the use of Surgical Centers is voluntary, we are publicizing these Surgical Centers approved for use in each area and are thereby acquainting employees with this relatively new procedure. One case reported, resulted in a savings of $358. Although it is too early to tell if this is typical, the results so far have been quite encouraging.

"Health Maintenance Organizations (HMO) - HMOs can be effective, and FMC is continuing its appraisal of this health delivery system. FMC provided the HMO option beginning January, 1977 at the Chemical Group Headquarters in Philadelphia. The HMO cost is about $25 per month (family rate) below the current FMC cost.

"Other steps in various stages of planning and implementation are as follows:

"Medical Plan Revisions

Second Opinion - A second medical opinion in the case of elective surgery is nearing the final stages of implementation.

Fee Schedule vs URC - FMC will take a conservative stand on any request to change from a fixed fee schedule to a usual, reasonable and customary schedule. Benefits under the fixed fee arrangement do not automatically rise with inflation. We will also attempt to convert URC plans to fee schedule plans.

Pre-Admission Testing - Some of our plans do not contain pre-admission testing. We plan to incorporate pre-admission testing in all plans.

Communication - Regular messages will be sent to employees and their families to educate and encourage good health and safety practices, including information on health care costs absorbed by FMC. These messages will be incorporated into local plant publications.

Community Action - Representatives of FMC management will be asked to participate on local hospital boards and health planning agencies to provide perspective on cost control, particularly in locations where FMC is a major user of health care facilities.

"The rate of health care cost increases severely limits our ability to make meaningful improvements in all of our benefit programs and still remain competitive and profitable, something that is not in the best interest of our employees."

5. *General Mills*

Known for taking the initiative in the HMO movement, General Mills' experience in terms of employee acceptance and cost reductions is impressive:

Enrollment

Year	% of eligibles
1973	20.3
1974	31.2
1975	40.8
1976	49.8
1977	56.9

General Mills (continued)

This growth occurred despite the fact that, until 1976, the employees had to pay a monthly contribution to participate in the HMO, and no contribution to remain in the group health insurance plan. Quoting from General Mills:

"Our satisfaction is based on the quality of health care rendered to our employees and their dependents, positive employee feedback, and preliminary indications that costs of health care under prepaid group practice plans may be contained better than under the traditional fee-for-service system."

6. *Greyhound*

Four structural changes in the benefit plan indicate the increasing willingness of employers to use the economic leverage represented by their plans to encourage more cost-effective medical care delivery:

a) coverage for pre-admission testing
b) coverage for ambulatory surgical facilities
c) reimburse out-patient services at the same level as similar inpatient services
d) for elective procedures, provide less coverage for in-patient services than like services obtained on an out-patient basis.

7. *duPont*

The duPont safety program has successfully addressed the health care cost problem by an aggressive effort to reduce injuries both on and off the job. Their latest data shows a lost time index "equal to about 1/20 of the norm for the chemical industry."

8. *TRW*

"As purchasers of health benefits, corporations have been unable to determine whether or not they and their employees are getting the best value for the dollar in such costly areas as hospital services. Valid and meaningful data is essential if any measurement of the services is ever to be attempted.

"Several corporations, therefore, including TRW, have begun setting up utilization data retrieval systems to get the necessary claims and patient data to be able to compare costs and services between locations and between hospitals.

"We are using an independent agent, Damm & Associates, who is furnished data through the insurance carriers and who in turn supplies only statistical summary data to the corporations. An individual employee's medical data is never revealed to the employer under any circumstances.

"The development of this retrieval system and the resulting data base will allow the purchaser to have the information available in order to decide which cost and quality control programs are appropriate, feasible and have a projected return on investment."

9. *Goodyear*

See Appendix for detailed report on Goodyear's role in health planning.

Further positive results of Goodyear programs include:

"Peer and Utilization Review

a) In 1975, Goodyear contracted with a PSRO for concurrent utilization review at the largest community hospital in Akron on a pilot basis. The hospital is now adopting this review system for all patients. The average length of stay has been reduced by one day, with this review being a contributing factor.

b) In Freeport, Illinois, the Company has a contract with a Medical Foundation for peer and utilization review. After the first year of operation, the length of stay was reduced by one-half day for a $30,000 annual saving on just 600 admissions."

10. *Occidental Life*

"Occidental's Rehabilitative Medical Resource Coordination program has as its goal the reduction of expense for medical services and supplies for catastrophically injured claimants covered under our comprehensive group major coverages. By inputting the expertise of our Rehabilitation Staff to assure the claimant treatment by selected centers specializing in these disabilities, we have been able to effect savings of up to 50 percent of the costs we would anticipate had the claimant used less skilled facilities for continued care. Also, by providing the services of trained Rehabilitation Nurses (extra-contractually) to assure that the home situation is ready to receive the claimant upon discharge, and providing periodic follow-up care to train the family in necessary techniques to care for the claimant and making sure he is following through with his treatment plan, we eliminate some of the costly complications so prevalent with these disabilities. This program includes payment for necessary equipment to accomplish the above which would not normally be considered covered expense under the contract.

"While this program may not appear to be one of cost containment, it has avoided expensive, long-term care which would otherwise have ensued and, thus, has reduced the aggregate healthcare costs of some of our insureds."

11. *SmithKline*

"a) COST CONTAINMENT AREA - Prescription Drug Reimbursement

EXPERIMENT/INNOVATION

. Approximately 100 Tulsa (OK) Metropolitan Area Community pharmacies are participating in a pilot project being conducted by the American College of Apothecaries for Oklahoma Blue Cross/Blue Shield in conjunction with the Oklahoma Pharmaceutical Association. Pharmacists are asked to supply the usual and customary prescription charge to the patient, and cost of ingredients, of 300 prescriptions chosen randomly from each participating pharmacy. The difference between the ingredient cost and the prescription charge will, in essence, be the fee charged for dispensing the prescription. All non-government prescriptions are included; i.e., employee third party pay, discounted, physicians.

SmithKline (continued)

The objective of the experiment is to determine if the use of usual and customary charge will reduce the paper work and other administrative costs of processing prescription drug claims by Blue Cross/Blue Shield, which now amount to over $2.00 per prescription claim. The project is presently restricted to Over-65 Plan subscribers and, if successful, will cover all Major Medical Plan subscribers.

"b) COST CONTAINMENT AREA - Hospital-Clinical Pharmacy Services

EXPERIMENT/INNOVATION

A program under which pharmacists practicing with the Ohio State University Hospitals Department of Pharmacy are reimbursed for providing clinical pharmacy services by the private third party program administor, Blue Cross of Central Ohio.

Five clinical services are covered: (1) A Total Parenteral Nutrition Home Care Program in which clinical pharmacists instruct homeward bound patients in the preparation, storage and administration of their own hyperalimentation admixtures; (2) Calcitonin - Salmon Drug Therapy Home Care Program for patients with Paget's disease; (3) Injectable Analgesics Home Care Program for patients with malignant or benign diseases; (4) Training hemophiliacs to administer Factor VIII at home; and (5) Cytobarine self administration at home.

Objective of the program is to help patients manage their disease conditions at home, thus reducing outpatient and emergency visits and/or reducing unnecessary and costly hospitalization.

"c) COST CONTAINMENT AREA - Prescription Drug Programs, Physician Services

EXPERIMENT/INNOVATION

A study designed to determine the cost per recipient for each service (e.g., physician services, drugs, etc.) and administrative costs in each of two types of programs. Comparisons of the cost per recipient will then be made for each of the services, administrative costs and the total cost per recipient in each of the two following programs:

a. A comprehensive Medicaid program which permits the physician to prescribe the prescription drugs of his choice without restrictions on therapeutic class, drug entity, brand or price; and

b. A comprehenisve Medicaid program which restricts the physician in his choice of drug therapy by any mechanism, such as restrictive formulary, mandatory generic prescribing, or maximum price.

Objective of the study is to determine the financial impact drug program design and policies have on the total cost of a Medical Assistance Program (total of all services). It is visualized that the study would analyze and compare the total cost per recipient for delivering health care (all services, e.g., physicians, prescription drugs, etc.), including administrative expenses.

NOTE: Study has not yet been initiated. Bids are being obtained from private sector organizations involved in health care studies."

12. *Connecticut General*

The following items are conducted for Connecticut General employees:

"a) Connecticut General has, in the past, been aggressive in introducing and administering programs to control the level of claim reimbursement. The oldest of these formal programs is called Claim Cost Control, which applies the contract provisions of 'usual and customary' physician fees, Coordination of Benefits, No Fault, and Subrogation. Claim Cost Control programs both restrict benefit payouts and impact on total health care costs. Excessive fees are identified and reduced sometimes permanently and the possibility for profiting on health insurance is removed. While the precise impact on health care costs is not directly measurable, during 1976, Claim Cost Control accounted for savings of 6% in benefit payments.

"b) Pre-treatment Review for dental insurance is another effective program that allows for the prospective review and agreement of the proposed course of dental treatment and its cost. Examining Treatment Plans for major dental procedures by dental consultants frequently surface situations where less expensive alternate treatment is satisfactory. During 1976, dental Pre-treatment Review accounted for savings of 12%.

"c) In February 1974, Connecticut General voluntarily extended Pre-Admission Testing benefits to all medical care policies at no cost. In addition, outpatient surgery performed in a doctor's office or in a freestanding surgical facility is covered in our contracts.

"d) CG's latest cost containment activity is Pre-Surgery Consultation ('second opinion surgery'), a prospective process of medical consultation on the necessity for non-urgent surgery. This program provides numerous advantages, including peace of mind for patients and their families, upgrading the quality of health care through the use of medical consultations, and education of patients. The program also presents the potential for significant savings in surgeons' fees, hospital costs, and disability benefits by avoiding unnecessary surgery. The program will be launched shortly.

"e) The potential benefits of improved health education are numerous. We will begin an extensive education program with our own employees by mid-year. Once this foundation of knowledge is established, we can develop or sponsor programs which are nationwide in scope.

13. *Employers Insurance of Wausau*

See Appendix for detailed submission with the HMO as the central feature of their cost containment effort.

14. *Equitable Life Assurance Society*

"The Equitable currently has some $450,000,000 of its assets invested in health related facilities such as hospitals, ambulatory care centers, etc. The Equitable has made a conscious effort to integrate its investment decisions with the actions and plans of local health planning agencies. As a matter of policy we have required that proposed health facility investments be submitted for certificate of need determination or where such programs do not exist to the local health planning agency (CHP "B" or HSA) for review and comment prior to our making an investment decision. We have tried to

Equitable (continued)

target our investments so as to increase the availability of ambulatory care, e.g., neighborhood health centers, and enhance the efficiency and effectiveness of community hospitals.

"We have just completed a study of the potential of the minimal care bed concept for patients who are convalescent and ambulatory and can participate in their own care. We are sufficiently impressed by its potential as a means for reducing hospital costs so as to include support for minimal care beds as one of our investment priority areas in the health field.

"It is our belief that by targeting our investments and integrating our investment decisions with the health planning process, our investments are having a positive impact on future health care costs and should not add to the supply of excess hospital beds."

15. *Ford Motor Company*

See Appendix for descriptions of:

1) Michigan Blue Cross/Blue Shield cost containment Program
2) Ford-UAW cost containment agreement

"Special Company Pilot Programs

In an effort to develop improved techniques for helping employees live more healthful and productive lives, the Company is pursuing pilot programs in areas that appear promising. The following is a brief description of three programs the Company is conducting:

a) Cardiovascular Risk Intervention - Through this program, we are screening people to identify cardiovascular disease risk factors and attempting to teach people self-management of their risk factors where that is practical.

b) Alcohol and Drug Abuse - At selected locations, a counselor is being made available for use by employees who have alcohol - or drug-related problems. At most plant locations, a system is in place to refer employees who may have alcohol or drug problems to appropriate community resources.

c) Hypertension Screening Program - A pilot program was conducted at one of Ford's plants and coordinated by a University of Michigan/Wayne State University team. This study screened employees for hypertension and provided an evaluation of employee awareness of hypertension and adequacy of treatment among confirmed cases."

16. *General Motors*

a) update on data contained in the December 1976 Council on Wage & Price Stability report:

	1976 Auto Model Year	1977 Auto Model Year
GM Premiums	$825 M.	$1.3 B
Monthly Cost - Michigan Family	$130	$140 by fall of 1977.

In addition, the GM corporate staff has added two full-time Senior Staff Assistants, one on the Financial Staff to work on health care planning, and one on the Industrial Relations Staff to work on health care cost containment.

General Motors (continued)

"b) During the 1976 negotiations, some minimal concessions were obtained:

1. Restructuring coverage design so as to provide more effective cost controls on present coverages and to redirect the obtaining of necessary health care from the hospital to a less expensive setting.

   . In the Coordinated Home Care area we eliminated the prior hospital or extended care facility admission requirement for admission to Home Care Program.

   . Increased from 50% to 100% the benefit paid for home health aides.

   . Added a Home Hemophilia Pilot Program for employees in Michigan.

   . Restructured the non-accident medical emergency benefit to try to discourage improper utilization of the outpatient hospital emergency department for non-emergency conditions.

2. Adding new coinsurance provisions or increasing the amount of present ones to certain existing hospital, medical, and prescription drug benefits in order to obtain or increase patient involvment at point of service.

   . Our concern was to get appropriate co-payments at point of service on diagnostic tests, in-patient hospital stays and surgery. We were not successful but did arrange for co-payments in Vision Program and an increase from $2 to $3 in existing prescription drug co-payment.

3. Helping to pay for health care coverages and premium increases by use of monies which might otherwise be paid out as wages.

   . Union rejected any movement in this area.

4. Phasing in of Corporation-paid coverage for new employees, based on service.

   . Delayed new hire eligibility from first of second month to first of third month after hire date.

5. Encouragement of programs and pilot studies involving various approaches and procedures designed to contain costs while maintaining or even improving quality of care. These include special medical necessity review programs, pre-admission or early admission testing, second opinions for elective surgery, and reimbursement on an advance budgeting basis.

   . The jointly agreed upon cost containment projects in response to this demand are set forth in the attached document entitled 'Understandings With Respect to Utilization Review and Cost Containment. (See Appendix)

"c) Negotiated Health Care Cost Containment Provisions Other Than Co-Payments:

A. Dental Care

1. Pre-determination of Fees

If planned dental services exceed $125 (formerly $100) for a patient, the dentist must get advance approval of carrier to perform procedures as planned.

General Motors (continued)

2. Alternate Treatmeant Plans

   Dental Carriers, with the help of dental consultants, make suggestions for quality effective but less costly alternate treatment plan.

3. The specifications also contained a major cost containment thrust in the areas of preventive care, early detection and post performance audits.

B. Prescription Drugs

1. Program limits a covered purchase to 34 day supply.
2. Certain legend drugs can be dispensed in 100 or 200 unit dosages

C. CAT Scanners

Only brain scans done on equipment approved by a local HSA are covered by payment.

D. Cardiac Stress Tests

The cardiac treadmill tests are covered benefits only when certain diagnoses such as recognizable symptoms of cardio-vascular disease, or abnormal physical or lab findings suggest the presence of cardiovascular disease.

E. Cost Control and Quality Assurances

Each of the newer health care benefit programs — dental, vision care hearing aids — contain provisions which require all carriers to provide any or all of the following types of control mechanisms:

- Utilization and peer review
- Price review
- Evaluation of services/clinical post-treatment evaluations

F. Since 1964 emphasis has been directed toward out-of-hospital care as a less costly method of providing needed care. These alternatives include full payment for diagnostic tests in our out of the hospital, up to 730 days in an extended care facility with or without a prior hospital admission, and out-patient psychiatric care.

"d) General Motors recognizes the seriousness of hypertension as an employee problem and currently has a pilot program for hypertensive screening at a GM division in Ohio. As a result of this pilot program, an internal task force has been established to develop a corporate-wide screening program for hypertension.

"e) An Interstaff Task Force on Cost Containment

General Motors recently formed an interstaff task force of representatives from the Industrial Relations Staff, Employee Benefits Section and Medical Section; the Financial Staff, Insurance and Pension Section and New York Treasurer's Office; Legal Staff; and Public Relations Staff.

The objective of the task force is twofold:

1. To determine how the pilot programs agreed to under the 1976 Collective Bargaining Agreement can best be utilized to bring about cost-effective changes in the medical care delivery system; and

General Motors (continued)

2. To develop innovative ideas for ongoing cost containment programs beyond the concepts embodied in the 1976 GM-UAW Insurance Agreement which may impact on General Motors' approach to health care delivery for its employees, retirees and their families, and also be of substantial assistance to community health care planning."

17. *R. J. Reynolds*

At the time of the COWPS report, the R. J. Reynolds HMO was just starting. They said then that it was hoped some 15,000 employees would eventually enroll. Today, just a few months later, 10,000 are enrolled and another 20,000 are on the waiting list.

18. *Deere & Company*

Their health plan was negotiated with the U.A.W. but is applied to all employees, including non-organized.

Deere & Company gave a grant to Iowa State Medical Foundation to help establish PSRO's ability to perform peer review and utilization review on private patients. Also meeting with Mid-State Foundation in Illinois to discuss the possibility of a grant for starting private patient review.

There is a provision in Deere's UAW contract which allows the company to cease reimbursement within 24 hours of PSRO/UR determination that medical service is no longer required. Under this provision, however, patient is held "harmless" and Deere will back him if out-of-pocket payment is demanded.

19. *PPG*

Major changes effective January 1, 1977

- Promotion of preventive care, early detection of illnesses, to keep people out of hospitals, to provide care in ambulatory/out-patient facilities that previously would only have been covered with hospital confinement.
- Diagnostic laboratory and x-ray coverage is 100%, hospital confinement is not required thus eliminating the need for a separate provision for preadmission testing.
- Recognize ambulatory care centers as covered institutions.
- Recognize use of drug and alcohol abuse centers, as opposed to general hospitals for care of those illnesses.
- Psychiatric treatment - "very important to have early treatment of psychological disability or mental ailment to lessen the possibility of it becoming a long-term hospital confined disability." Recognize qualified clinical psychologists and have the benefit on an out-patient basis with a reimbursement schedule to promote early care.

PPG (continued)

- Dental care is also reimbursed on a schedule designed to emphasize preventive care:

  100% reimbursement of semi-annual dental examination

  80% reimbursement of restorative work

  60% reimbursement on major treatment

20. *Alcoa*

Alcoa has one of the most comprehensive corporate programs stimulated in part by a 23.9% increase in medical costs between 1974-75, with no major changes in their benefit plan. Their total health care costs in 1975 was equal to 71% of net income...enought to get anyone's attention.

Their program involves:

- encouraging HMOs (to date the HMO rates are below their insurance premium).

- having employees serve on HSAs, and, through the Alcoa Foundation, providing financial support for HSAs.

- establishment of a Special Ad Hoc Working Group on Cost Containment and Cost Effectiveness.

- involvement on Hospital Boards

"For many years Alcoans have served on boards of hospitals in the communities in which we are located.

"Earlier this week (March 18) we surveyed 16 locations where we have plants and found that 19 Alcoans are serving with hospital boards, 15 as board members and four as presidents of the hospital board.

"In two of these locations there is an interesting story to tell:

. At one West Coast location the manager of our plant was the key to consolidation of two community hospitals. Over a four-year period the manager in addition to attending the board meetings of the hospital, attended more than 50 meetings, some of which involved trips to communities as far as 100 miles away, to learn from the experience in those communities.

It is estimated that this consolidation will save the community $325,000 a year and will have a significant reduction in capital improvement without sacrificing the quality of care. Our manager was joined by representatives of several other companies in helping make this consolidation possible.

. At another location in the Midwest the manager of our facility has been working for over 5 years to accomplish a merger of two community hospitals. The merger attempt was undertaken when one of the two hospitals proposed to the Community Health Planning Agency a $12 million expenditure. The Community Health Planning Agency turned down the request. It was appealed to the State and Regional offices and turned down by both offices. The Agency did recommend merger discussions.

Alcoa (continued)

The manager was chairman of a task force which undertook the study to consolidate. The activities of our manager along with other industrial and civic leaders in the community have resulted in Articles of Incorporation approved by both boards and a total of 18 other points for consolidation.

"Recognizing the importance of having responsible people serve on hospital boards we have developed a hospital trustee training program which will be used to train all Alcoa employees appointed to hospital boards and will be made available to any hospital boards who wish to use it."

- extensive off-the-job safety program

"We studied off-the-job injuries at one plant. We found that in one year 111 employees were injured; four of them fatally. We estimated a total cost of $340,000 for that one year — NOT including survivors' benefits or many of the indirect expenses which arise when an employee is injured. Working with the safety department, we propose to set up more off-the-job safety programs on subjects such as:

defensive driving	camping	power tools
boating	snowmobiling	bicycling
skiing	firearms	home safety"

- health education

"We are increasing our efforts in health education...efforts for both employees and their dependents...so they know more about cancer, emphysema, obesity, diet and so on. There is ample evidence that what this country needs is behavior modification on the part of its citizens if better health as a goal is to be obtained. All national health insurance proposals are aimed basically at more health services, thus they might better be called national medical insurance proposals. But, unless we can influence life-style, revise our debilitating behavior patterns, it seems unlikely that we can produce effectively better health for the population, no matter how much we spend on traditional health care."

21. *Corning Glass*

Benefit plans are being changed to provide coverage for second opinions on elective surgery cases. Noting that "these programs can be effective in large metropolitan areas," Corning cautions that, "they lack force in smaller communities. We know from experience that the medical community in our (small) localities are a close-knit group and tend to take care of each other."

22. *IBM*

The effectiveness of multiphasic health testing programs has been seriously questioned. Evidence from many companies would suggest that selective screening with adequate follow-up is valuable while blanket testing of entire

IBM (continued)

employee populations may not prove cost-effective. IBM's experience, among the most thoroughly documented, shows exciting results. Begun in 1969, their program is voluntary and is available to all employees age 35 and over. Results on three diseases are:

1. Hypertension :	1st exam :	80,515 tests	
		2,135 detections	
	Repeat exam:	26,779 tests	
		2,846 detections	
2. Heart disease:	1st exam :	454 detections	
	Repeat exam:	577 detections	
3. Diabetes	1st exam :	111 detections	
	Repeat exam:	110 detections	

23. *Rockwell International*

Rockwell International, along with other Michigan employers, provides its employees with a prepaid dental program through the Delta Dental Plan of Michigan; one of 47 State, non-profit service corporations that comprise the Delta Dental Plan Association. The plan seeks to assure covered individuals with access to high quality dental care at a reasonable cost. It also seeks to assure cost and quality controls through sophisticated in-office fee audits and a patient care review program.

Participating dentists (now about 83% in Michigan) must accept plan reimbursement as full payment. Payment is made on a traditional reasonable and customary basis, with a maximum set at the 90th percentile. If the filed fee is above this charge, reimbursement is cut back to the 90th percentile level.

All claims are referred to a consultant for screening before payment is made. This review process checks to see:

a) if accepted dental standards were used
b) if dental services rendered were not abusive to the policy
c) if services rendered conflict with stipulated coverages.

It is estimated that Delta Dental of Michigan achieved a $500,000 savings last year and as much as $900,000 over the past two years, as a result of this review activity.

Rockwell International (continued)

Delta also has personnel on the road to audit the fees of participating dentists in their own offices. This fee verification practice assures that plan participants are not being charged more than non-insured patients receiving the same services. If there are discrepancies that cannot be resolved at this initial contact, a grievance committee has been established to resolve disputes. To date, 2,400 office verifications have been performed.

Professional review of patient care is the last phase of cost and quality controls provided. A dentist from the Michigan Dental Association performs a review of dental work claimed. This requires employer cooperation and is performed at employer provided locations or in nearby union halls. Randomly selected patients are examined to make certain work paid for was of high quality. A 3-4% discrepancy rate has been uncovered by the more than 3,000 patient reviews performed.

As a result of professional review activities during the past year, the participating status of six dentists was revoked. In three of these cases, participating status was lost due to non-performance of care. In the remaining cases, noncomformance to Delta's policies was the reason for termination of participating status.

24. *Continental Bank*

Two of our members, *Continental Bank* and *The Harris Trust and Savings Bank* have been providing leadership, within the banking community, on health policy and cost issues. They have formed an ad hoc bank group in Chicago and are in the process of doing the same with the New York City and California banks: Citibank and Bank of America are taking the lead after initial meetings.

The following describes part of the evolving cost containment program at the Continental Bank.

"We propose to help employees become better health care consumers by educating them at the time they plan to make use of major health services. It is our feeling that the employee/patient today does not have the necessary information on which to base a rational consumer decision. The patient often follows the doctor's fatherly advice without question as to the necessity for recommended medical or surgical treatment. Many patients consider it to be "bad form" to ask the doctor about his fees. The doctor in this case is viewed as a life saver. Putting a dollar value on life is impossible, especially when it is your own.

Continental Bank (continued)

"Effective May 1, 1977 our personnel employee benefit health insurance claim administrators will begin to consult with employees before a hospital stay. Through an experimental second opinion for elective surgery program with Chicago Blue Cross/Blue Shield, the patient will be able to assess the necessity of recommended treatment. Employees who wish a second opinion will be given a list of three certified specialists who they can consult with or without their doctor's knowledge to obtain a second or even a third opinion on the course of treatment recommended.

"Our Blue Shield insurance plan covers 80 percent of usual and customary doctors' charges. When a doctor charges more than usual and customary, the patient pays 100 percent of the excess. Today when this happens it is a surprise to the patient. After the care has been rendered he or she finds out from Blue Shield that a portion of the bill is not covered.

"Effective May 1 we will be able to provide information about the impact of usual and customary charge limits to employees who have obtained detailed price and treatment information from their physician before treatment is rendered. An employee who asks his or her doctor to write down his fee and the procedure he plans to use, using medical terminology, can come to our employee benefit office and find out beforehand if part of that fee will be beyond usual and customary limits. This, then, will provide him information with which to judge the doctor's price and eliminate the useless surprise when it is too late to do anything. This 'predetermination of benefit' is being done as a joint experiment by Blue Cross/Blue Shield and Continental Bank."

25. *George B. Buck Consulting Actuaries*

"Recent statistics on qualified HMO's show average hospital utilization of about 450 days per 1,000 compared to national statistics close to 1,000 days per 1,000. It is important to realize that the the HMO statistics include plans without effective inducements to reduce hospitalization. Those plans with direct financial incentives, such as the Health Maintenance Program of the Wisconsin Physicians' Service, have experienced rates of 300 or less. If Hospital costs comprise 60% of the health dollar, it is easy to see aggregate savings of 25%, even after allowing for increases in direct physician and laboratory charges. Deferred savings from the long range effect of preventive care are a bonus."

95-195 O - 77 - pt. 2 - 59

26. *Procter and Gamble*

Procter and Gamble is working with the Mid-west Foundation for Medical Care which operates in the Cincinnati area. The foundation employs full-time nurses to conduct in-hospital reviews of admissions, lengths of stay and discharges. The program has 85-90% participation by physicians...began 3 years ago...now has 202,620 "members" through 2,441 groups and 81,991 individual contracts. The cost per concurrent utilization review is $16.50 per admission. Professional fee claims reviews cost $25.00 per claim.

The results, as of November -76 show that the average length of stay for patients under 65 was:

Foundation members:	6.42 days
non-members :	7.73 days

PART II

HOSPITAL COST CONTROLS

The Problem

For many years, the money spent on health care in the United States has grown at a rate sufficient in both absolute and proportional terms to cause concern. During the period since the Economic Stabilization Program's freeze was removed, the rate of cost escalation has been so large as to cause that concern to become real alarm.

Coincidental with the attention drawn to the cost issue have been two movements with vast financial implications and deep value conflicts:

A. Comprehensive national health insurance
B. A realization that personal and societal life styles are the prime determinants of health status.

These two, combined with the cost issue and the general awakening that all of our natural and fiscal resources are indeed limited have caused "health" to become one of the topics most consistently in the news, on the political agenda and on the minds of the public.

It is, therefore, not surprising to find both the outgoing Ford and in-coming Carter Administrations proposing rather drastic measures proporting to gain some measure of control over health care costs.

This Working Paper will briefly examine some of the causes of the problem and will highlight some of the proposal's pros and cons.

Causes

There is no single cause for today's health care cost "crisis." And, just as surely, there will be no single solution.

Much has been written about the social, economic and political forces which combined with the historically unchallenged autonomy of the health professions to produce our current system.

Certain key causes stand out:

A. unbounded public expectations that medical care can solve all health problems.

B. vast public and private economic stimuli for the growth of medical facilities without regard to any real measurement of need, resulting in the overbedding problem.

C. the dichotomy between the need to remove financial barriers to needed care and the need to impose a measure of cost consciousness on the consumer. Employment-based group insurance plans have been part of this problem. That is just one more reason why they must be part of the solution.

D. the near total inability of the consumer to influence the type, or cost of care purchased...the seller is given the unique authority to control both the supply and demand side of the medical market place.

E. uncontrolled access to the market for new medical technology.

F. the absence of any process to force the development of and compliance with medical standards.

G. a level of societal affluence that has contributed to decades of inattention to personal responsibility for health maintenance.

H. a reimbursement system that, for years, has placed the economic incentives on the most expensive, rather than the most appropriate, care and care delivery methods.

In sum, then, we have a medical system that is doing exactly what we have asked it to do. And to think that the medical and health industries will react to the ebbs and flows of economic incentive in any other way is to be hopelessly naive.

Therefore, it is of paramount importance that we evaluate the hospital cost control proposal from the standpoint of its potential impact upon those economic incentives which we today feel to be causing the waste in our health and medical systems.

The Proposal

As long as the cornerstone of the proposal is a uniform percentage cap on hospital expenditures we feel the proposal simply cannot be effective. And we say that quite apart from any aversion to price controls.

In discussions which have now lasted for a full month, we have not found one employer, one labor official, one economist or one health professional who feels that such a cap will really work.

In addition, the proposal will take at least one year from the time of enactment to show even temporary progress due to the amount of growth already financed and approved by the HSA-Certificate-of-Need process. Thus, it will not be a "quick fix." Which, in turn, raises the incredibly complex question of how to end the "freeze" without a resulting catch-up price inflation.

The fact is we see no evidence that capping hospital costs will actually reduce the total amount spent on medical care. It is simply too easy to get around the cap by increasing utilization; or by using ambulatory and free standing surgical centers; or by leasing space, even within the hospital, to physician groups...the alternatives are as endless as the imagination.

To prevent such shifting of costs would require an administrative and regulatory structure, the cost of which could be as prohibitive as its effectiveness would be questionable.

And no safeguards could prevent the simple delay, through reduced supply and the threat of reduced reimbursement, of elective procedures until the freeze is lifted. Since the concept is not designed to be a barrier to emergency care, it is the elective area which must show all savings.

The problems faced by national employers in the administration of their health benefit programs can serve as a model for the problems that would, to a substantial degree, face the federal government in the conduct of a new health program.

One of the clearest lessons to be gleaned from the corporate experience is the value of designing programs to reflect local conditions. This is consistent with the design of government's health planning system, the federally funded HMOs, the PSRO program and the intent of the manpower legislation passed in the 95th Congress.

Therefore, the State-wide waiver where an acceptable State prospective rate review system exists is viewed as a very positive approach.

Three States now seem to meet that criteria (Connecticut, Massachusetts, & Maryland) with several others in various stages of development. The experience in Indiana would indicate that good results can come from a voluntary program. In fact, when the factor of administrative costs is included, the voluntary may well be more effective than the mandatory approach.

Quoting from a 1974 Social Security Administration funded study "...the program's overall emphasis on meeting the financial requirements of hospitals, rather than controlling their costs, IHA and Blue Cross point out that the actual record of cost containment in our State is considerably better than for the nation as a whole. In 1972, for example, for short term hospitals, Indiana's increase in per diem operating costs over 1971 was 11.3%, compared to the national average of 13.8%; the case cost increase in Indiana was 8.6%, compared to the national average of 11.5%. Salary scales are currently about 5% lower than the national average and at the same time, Indiana hospitals also have kept their rate of increases in hospital staffing below the national average. Furthermore, this favorable cost containment record has been evident all through the post medicare period of rising hospital costs."

An American Hospital Association survey of existing State rate review programs showed the following:

State	# of hospitals involved	Type of Program	Cost
Connecticut*	35 hospitals & 250 nursing homes	Mandatory	$ 500,000
Massachusetts*	204 hospitals & 983 nursing homes	Mandatory	1,640,000
Maryland	55 hospitals	Mandatory	510,000
Indiana	121 hospitals	Voluntary	90,000
New Jersey	106 hospitals	Mandatory	2,373,901

*does include Medicaid

Another way of measuring system & incentive change is to look at the trends in outpatient visits per 1,000 population

Year	Indiana	U.S.
1975	899	894
1974	866	894
1973	743	825
1972	700	800

The increase in Indiana came despite a leveling off of in-hospital length of stay and a per diem rate $20.00 under the national average.

All of this does not suggest that Indiana has all the answers. But it does suggest that the voluntary approach clearly warrants serious examination.

If adopted, the State waiver should be based upon performance criteria thus allowing mandatory or voluntary rate review programs to flourish as long as they meet the criteria.

Other positive aspects of the HEW's approach include its emphasis upon:

- prospective reimbursement
- outpatient incentives
- cost containment experiments
- incentives for the transfer of unneeded acute care back to needed skilled nursing beds

Two additional points need to be made. The Adminstration is to be complimented for taking a leadership role in this difficult and politically, highly charged issue. No matter how much we may disagree on methods, there is no question that we support and applaud the objectives

Secondly, the decision to make the proposal effective "across the board" rather than just for Medicare & Medicaid is good. That does not imply that we favor price controls. But it does clearly state that employers are glad to see an Administration which recognizes that to impose any cap on a less than total basis would simply mean a shifting of all "restrained" costs to the private sector.

We have several other concerns. The cost savings in the short-term may prove to be illusionary since most will come from capital expenditures which are simply delayed rather than prevented. And, when done later, they will cost even more.

There is the very real problem that costs to hospitals can be raised in anticipation of the cap yet no retroactive clause can reach those costs because they are external to the hospital itself.

A price cap will undermine the HSA and State certificate of need programs. We feel that any cost control program should be designed to encourage these planning systems.

There is a very human issue to be considered. Many poor people will simply not be accepted by either proprietary or private not-for-profit hospitals and, the emergency room access point for the poor will also be curtailed. Since illness and injury cannot be "capped" by regulation, there will be a resulting over-demand upon public hospitals at all levels of government. And, of course, the total health care "bill" will not be significantly reduced. Ironically, it will be Medicaid patients who are among the first to suffer as assignment ratios drop even lower.

APPENDIX

MOBIL OIL CORPORATION

(Statement prepared by the company)

"Mobil Oil's management has approved a new and unique employee benefit effective February 1, 1977 - *a Contribution Bonus*. This Bonus will be paid to those groups of employees participating in the Comprehensive Medical Expense Benefit Plan who have succeeded in keeping the actual cost of their Plan below the maximum contribution the Company has agreed to pay.

"For the purpose of determining claims experience and plan rates, Mobil Oil employees are divided into ten geographical areas. Once every year, usually July 1st, the Plan cost is established for each area based on the previous year's claims experience. Beginning February 1st of this year, each month during which the actual cost of the plan in an area is less than the maximum Company contribution, employees in that area will be credited with a bonus equal to the excess contribution. At the end of December, 1977, employees will be paid a separate check equal to the amount of their accumulated monthly bonuses. The bonus will be taxable income and subject to applicable Federal, State and local withholding. The current rates established last July for the New York Headquarters employees are listed below along with the current monthly bonus.

Monthly Rates and Contribution Bonus - Effective February 1, 1977

	Personal Coverage	Family Coverage
Maximum Company Contribution	$26.50	$62.00
Less Actual Plan Cost	22.20	54.20
CONTRIBUTION BONUS	$ 4.30	$ 7.80

Plan costs are reviewed each July; the Contribution Bonus will change each time the Plan cost changes."

GOODYEAR TIRE & RUBBER COMPANY

(Statement prepared by the company)

Health Planning: activities and results

The Company's commitment has involved support of the local health planning process with both management time and financial contributions. In Akron, Ohio, the Company has actively participated in health facilities planning through the Health Systems Agency of Summit-Portage County. The Company's Manager of Health Service Industry Relations has been President of Health Systems Agency since 1975. Six other Company managers are involved in board and committee activities. Following are the results of the HSA Project Review Process:

Project Review - August 1974 to February 1977	
Hospitals	30 projects
Total	$121,346,332
Approved	52,785,332
Disapproved or Withdrawn	68,561,000
Long Term Facilities	13 projects
Total	$ 20,915,886
Approved	9,411,000
Disapproved or Withdrawn	11,384,886
Other Services	
Total	$ 543,000
Approved	543,000
Total Projects	$142,805,218
Approved	62,859,332
Disapproved or Withdrawn	79,945,886

The following provides specifics of the review of four major hospital proposals shown in the above.

1. A 500-bed hospital proposed construction of an Ambulatory Care Center at a cost of $7,127.000. The proposal included refinancing of current debt as well as the new debt at 9.75% interest. The HSA negotiated with the hospital to investigate financing alternatives. The hospital withdrew the project and developed a new financial plan which did not include refinancing of current debt and scaled down the project to a cost of $6,733,000.

Result:	Capital Saving	$ 394,000
	Dollars saved over 10 years due to new financial plan	$12,000,000

Goodyear (continued)

The hospital has also agreed to provide the HSA with the following:

— A quarterly report on construction progress and costs.

— A quarterly report on utilization of services.

— That total construction costs will not exceed $6,733.000

— A progress report on efforts to reduce the average length of stay by one day by 1978.

2. A 600-bed hospital received approval for a major modernization and expansion project. The HSA and hospital worked together for one year to jointly plan for this needed project. An agreement was made that the hospital would reduce manpower by 63 full time equivalents in 1979 and reduce the average length of stay by one day.

   Result: Savings of $7,750,000 over 10-year period.

3. A 400-bed hospital and the HSA developed alternate financing of a $7,054,360 modernization and expansion project.

   Result: Savings of $794,212 over 10 years.

4. In 1975, the HSA disapproved a new 250-bed hospital in the community. The disapproval was upheld through the appeal process.

   Result: Savings of $22,000,000

NOTE: The Summit-Postage Health Planning Area has a population of approximately 700,000

COST CONTAINMENT ACTIVITIES OF
EMPLOYERS INSURANCE OF WAUSAU
IN THE HEALTH CARE FIELD

(Statement prepared by the company)

This concise paper will briefly summarize cost containment activities of Employers Insurance of Wausau. Although many things affect the cost of health care, three components emerge that affect insurance premiums. Stated simply, those components are:

1. The utilization of services which in part are controlled by both medical providers and consumers.
2. The fees and charges billed for the utilized services.
3. The administrative charges incurred in paying for and the controlling of the services.

Let us first look at the cost containment activities as they exist in the HMO setting and as they relate to the above three components of cost:

1. Utilization of services

   The hospital certification program — A concurrent review process used to control both unnecessary hospital admissions and length of stay. Both admissions and length of stay are certified as to necessity with physicians being "on risk" for such activity.

2. Preadmission testing

   A program administered to eliminate unnecessary hospital admissions as well as unnecessary duplication of diagnostic testing prior to and during hospital confinement.

3. Health and plan education

   A formalized program to educate both providers and consumers on insurance principles, medical care financing, medical care delivery, and health related postures. Appropriate utilization of available services is discussed with an example being the unnecessary use and/or abuse of 24-hour emergency room facilities.

4. Ambulatory Peer Review, both quality and utilization assessment programs

   In this setting, all ambulatory utilization is reviewed using a number of different reports and statistical profiles. For example, family by patient profiles are monthly reviewed to measure quality and utilization of care rendered by all providers involved in the delivery of services to a family. Physician specialty comparisons whereby profiles are reviewed by specialty, comparing the utilization of services by a physician in comparison to his peers. Reports summarizing by primary care physician the care utilized and the cost thereof for all services delivered to a patient by all medical providers. For example, the cost of care delivered by a primary physician in addition to the cost of care delivered by his peer who provides off-time coverage, in addition to the cost of care for referrals made to specialists within the area in addition to the cost of care delivered in the institution setting as well as all out of area referred care. In pursuing the utilization of services and the cost containment activities therefor, we find that annual family profiles are sent to each enrolled family which totally outlines the care delivered to the family,

Employers Insurance of Wausau (continued)

by whom the care was delivered, the dates that it was delivered, the charges made for the services, and the specific procedures performed. This tool is both informational and serves as an audit by patients, reviewing the billed services and the cost thereof.

5. Fees and charges

The HMO through the operating committee, negotiates fees and charges with all participating medical providers — physicians, institutional providers, ambulance companies, etc. The fees are guaranteed for 12-month periods and through appropriate coding, are locked into a computer system.

Through committees such as the operating committee and Peer Review Committee, the accounting and charging practices of medical providers are monitored and controlled. For example, should outpatient surgery charges be unbundled whereby specific charges are made for the office visit, surgical procedure, surgical tray, suturing, removal of suture, follow-up care, etc. By the unbundling of charges in order to produce detailed statistics for peer review, will the cost of care be affected.

6. Administration

The HMO has significantly mechanized the payment of claims with increased use of computers. Because of the single benefit package design, because of the guarantee of fees, and because of the detailed coding structure used for both procedures and diagnoses, "On-Line, Real-Time" mechanization was feasible. This, of course, eliminates the need for claim forms (in favor of encounter forms used in the physicians' offices), eliminates the need for patient billing because of the broad benefit package, and because of contractual relationships with medical providers, allows for a mechanized payment schedule whereby hospitals are paid weekly by a single check supported with appropriate documentation while physicians being paid monthly utilizing the single check supportive documentation concept.

The mechanization further allows that remote "On-Line, Real-Time" terminals are utilized to an efficient degree for fees and charges to be directly input or entered into the main frame system from medical provider offices.

These are but a few of the specific cost containment activities interwoven within the HMO setting. The controls, so to speak, are tied together by the assumption of "risk" by physicians. Very briefly, the physicians' billings are paid from a "physicians' fund" for which the physicians bear 100 percent risk. From this fund payment is made for participating physician charges, out-of-area physician referral charges, outpatient hospital charges, etc. The "physicians fund" income comes from a "capitation" which in total represents the maximum amount that is payable without risk. Ten percent of the physician's guaranteed fees are withheld during the year as a hedge against the possibility of a deficit, but there is not maximum risk limitation.

In addition, unnecessary inpatient utilization and the controls thereon are brought together by an additional "risk" factor borne by physicians. This is accomplished through the "Peer Review structure" and a specific "policy" related to the handling of non-certified admissions and/or length of stay. After a series of penalties, a physician could entirely be responsible for all inpatient hospital and physician charges incurred in connection with a non-certified admission and/or length of stay.

Finally, the coordinating force that monitors the effectiveness of the controls and the effectiveness of the incentives is the committee structure of the HMO. The HMO

95-195 O - 77 - pt. 2 - 60

Employers Insurance of Wausau (continued)

has an operating committee (policy making committee), a Peer Review Committee (a quality and utilization assessment committee), and a "citizens advisory committee" (a consumer forum to monitor the plan and make recommendations for future direction). In summary, this committee structure reenforces the "partnership theme" of the management of an HMO whereby those who deliver care and those who finance care are brought together in a partnership close relationship to assure that high quality yet economical care is being delivered and financed. No longer is it acceptable to have an arms-length relationship between those who deliver and those who finance health care services.

Many things have been learned through our experiences in working closely with medical providers. The knowledge we have gained is used to apply to other lines of insurance. Several demonstration projects, for example, have been utilized both within the HMO setting and within the traditional health insurance setting as well as the workers' compensation line of insurance. For example, guidelines are developed for the CT Scanner utilization and various options are offered to our customers with respect to coverage with, of course, recommendations being made. Guidelines were written with respect to the utilization of mammographies because of the potential cost of unnecessary utilization. The involvement of the citizens committee in the whole area of outpatient psychiatric benefits was requested, and as a result a specific outpatient psychiatric proposal formed with the help of psychiatrists — included therein was a specific peer review process for the monitoring of such outpatient mental health services. We have impacted on bylaws of institutional providers if they represent conflicts to cost containment activities. For example, the whole area of preadmission testing and the requirements of institutions for certain diagnostic testing upon admissions. Also, the charging practices related to staff anesthestists versus anesthesiologists.

In addition, guidelines have been drafted for the payment for and the reading of EKG's to eliminate unnecessary payment to those providers not qualified to properly interpret such diagnostic tools. Finally, the utilization of clout by peer review committees when it comes to the assessment of utilization and the capability of denying unnecessary utilization through a "retrospective" and retroactive denial process whereby the consumer cannot be billed for denied charges. This latter point applies primarily in the ambulatory area referring to services delivered by physicians therein.

In the health planning arena, our company is deeply involved in sitting on committees of both local and state HSA's. In addition, we participate in committee activities of state rate review processes as well as activities pertaining to insurance industry input to state PSRO activities.

In all, what is learned in the various settings and cost containment activities that are underway, the goal is to apply our knowledge to other lines of insurance. For example, the concurrent hospital certification program that has been so successful in reducing length of stay, admissions per thousand, and days confined per thousand, is being utilized on all workers' compensation admissions in various Wisconsin communities. In addition, we are attempting to develop, in certain communities, only concurrent hospital certification programs for the benefit of traditional health insurance where no HMO might exist within the near future.

From the monitoring of utilization and fees and charges, we are able to better design benefit packages for our policyholders and we are better able to determine the

Employers Insurance of Wausau (continued)

cost of specific benefit packages because of the statistics gathered which profile such benefits from a utilization standpoint, fee and charge standpoint and, of course, an administrative standpoint. The company has also undertaken, in the past, special screening programs — a good example being the hypertension screen. Additionally, the outcomes of routine comprehensive physical examinations are continually monitored to determine the appropriateness of such type services.

All in all, we see great potential for specific cost containment activities, especially when they are pulled together by financial and other incentives such as "risk." For example, in the North Central Health Protection Plan, a Wausau based HMO, the physicians bear some 65 percent of the risk of the total Plan which has been developed through close relationships of Employers Insurance and the physicians. Additionally and through risk assumption in regard to inpatient hospital utilization, we find that our HMO experience is a real eye opener in that length of stay is 4.3 days, days confined per thousand is 469, and admissions per thousand hovers around 100. These statistices represent drastic reduction in comparison to pre-plan statistics whereby length of stay was 7.4 days, days confined per thousand was nearly 800 days, and admissions per thousand was over 120. Other statistics such as those applicable to the delivery of ambulatory services have shown remarkable results. For example, the number of office calls per person insured per year hovers around 2.2 to 2.8, as we compare data of the five HMO's that our company presently sponsors.

FORD MOTOR COMPANY*

(Statement prepared by the company)

Examples of Michigan Blue-Cross/Blue-Shield Cost-Containment Projects and Objectives

- Overbedding - Identification and elimination of excess hospital beds is a major objective. Overbedding increases health care costs through unnecessary utilization to keep beds filled or the carrying cost for an empty bed — estimated at 40% to 60% of the cost of an occupied bed.
- Utilization Review - To reduce the length of stay in the hospital and prevent unnecessary in-hospital services from being rendered, BC/BS has mandated and implemented (effective January 1, 1976) a concurrent Utilization Review Program as one of the major cost-containment efforts. This program requires that all participating acute care hospitals concurrently review all admissions and extended stays to identify unnecessary ones.
- Malpractice Insurance - Development of self-insurance or pooled association programs is being pursued so that hospitals and doctors will not have to pay the extreme increases in premium costs being demanded by insurance industry. Also, the use of arbitration procedures is being promoted as an alternative to litigation.
- Purchase of Durable Medical Equipment - Provider reimbursement for expensive equipment is contingent on the approval of the area planning council. If this is not done, unnecessary purchases of expensive equipment will result in higher costs through overutilization of the equipment, e.g., CAT scanners.
- Pre-Surgical Screening - A study program has been implemented to determine if an added consulting doctor's opinion will reduce the amount of surgery performed.
- Provider Reimbursement - Ceilings were implemented on the amount of increase per service a provider could receive during 1976, and work continues on longer-range reimbursement controls, e.g., prospective or annual budget programs.
- Hospital-Based Physician - Criteria for allowable costs for reimbursing hospital-based radiologists and pathologists has been tightened.
- Productivity - Studies are being conducted on tecnhiques for improving hospital efficiency. Results will be made available to all hospitals.
- Benefit Design - Proposed benefit changes are being developed that would encourage more efficient use of health care services, e.g., benefits that encourage out-patient treatment.
- Generic Drugs - Programs are being developed that would encourage the use of generic drugs on both in-patient and out-patient bases — requires establishment of bio-equivalency norms and education of doctors and pharmacists.
- Pre-Admission Testing - A pilot program is being implemented to allow payment for required diagnostic testing on an out-patient basis prior to hospital admission, even if a subsequent admission is found to be unnecessary. Intent of program is to reduce length of hospital stay.
- Ambulatory Surgical Centers - A pilot program has been designed to encourage out-patient treatment for minor elective-surgical procedures in order to avoid in-patient hospital charges.
- Alcohol and Drug Abuse - Program has been implemented that pays for treatment in freestanding residential-type programs.

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*It should be clarified that this work also involves General Motors and Chrysler

FORD MOTOR COMPANY (continued)

The Michigan BC/BS Concurrent Review program is mandated for all participating acute care hospitals. They estimate a reduced length of stay of 1/3 day during the first 6 months of the program (1/1/76-6/30/76). Savings are estimated to be worth $4.3 million. BC/BS accounts for about 50% of all hospital days in Michigan.

Hospitals are required to provide a Utilization Review coordinator (usually a nurse) to review admissions to acute care hospitals. The coordinator will:

— seek immediate patient discharge if admission is deemed unnecessary.
— assign a review date if patient is admitted equal to the 50th percentile length of stay for treatment or cure prescribed.
— review case daily if no diagnosis was determined at time of admission
— refer case to special concurrent review panel of M.D.'s for review if patient's length of stay reaches the 75th percentile.

— take M.D. out of the middle if patient wants to remain in the hospital unnecessarily.

Hospital staffs are developing new capabilities.

**Where a PSRO is operational, it conducts concurrent reviews instead of hospital.

BC/BS is also attempting to coordinate public and private efforts.

Michigan Medicaid: undertook similar program for concurrent review: from 1974-1975 (1 year) the length of stay was reduced by ½ day which was largely attributed to concurrent review. Savings was estimated to be $14,000,000.

SUMMARY OF FORD-UAW COST CONTAINMENT PROGRAM

. Hospital Utilization Review

— Retrospective review — after-the-fact examination of the appropriateness of hospital admissions and lengths of stay. To be effective in the 21 Blue-Cross plan areas with 1,000 or more Ford employes.

— Concurrent review — examination of the appropriateness of individual patient admissions and planned lengths of stay while the patient is hospitalized. To be effective in at least three plan locations.

Goal - Each plan to progressively attain the highest level of utilization review possible.

. Annual Cost Containment Reports

— Annual reporting requirement of all Ford health carriers to include:

- Description of activities
- Results or savings of cost containment activities
- Cost containment problems
- Cost control plans for coming year

Ford intends to share the submitted cost containment ideas among all of the plans for implementation where appropriate.

**The major cost containment elements of this agreement are not solely for Ford, and apply also to Chrysler and General Motors

Summary of Ford-UAW Cost Containment Program (continued)

. Pilot Programs

- Second-opinion consultation — pre-surgical consultation provided to a member who has been advised to have elective surgery (three locations).
- Pre-Admission Testing (PAT) — tests conducted on an out-patient basis prior to a surgical or medical admission (two locations).
- Independent review — PSRO or medical foundation performing admission and length of stay review as well as quality of care audits (two locations).
- Model treatment screens — quantity and quality of patient care evaluated utilizing accepted medical criteria. Provider education undertaken when aberrant practices are identified (one location).
- Dental auxiliaries — use of dental assistants to perform some services normally done by dentist (one location).

. Other Programs

- Other cost containment programs may be developed which the Company and union believe will have positive results, such as improved hospital ancillary control of overbedding, free-standing surgical centers, and promotion of group practice plans.

ALCOA

(Statement supplied by the company)

HEALTH SYSTEMS AGENCY OF SOUTHWESTERN PENNSYLVANIA

Project Review Case Study
St. Johns General Hospital

SUMMARY

HSA review of the St. Johns General Hospital Plan/Program for Development found that the project was not an acceptable plan for the future provision of the needed services in the Allegheny Northwest area. As a result of a negative recommendation by the HSA, the potential long-range cost of approximately $70 million associated with the construction project was avoided. With the assistance of the HSA, St. Johns and neighboring hospitals are presently involved in a planning process aimed at identifying other, less costly alternatives for meeting the health care needs of the community.

BACKGROUND

The Allegheny Northwest planning area comprises an area essentially north and west of the city of Pittsburgh, bounded to the north by Butler County and to the northwest by Beaver County. Nineteen major health care facilities serve the area, including six community hospitals, a regional hospital, a rehabilitation facility, a home for crippled children, and ten nursing homes. There are also four neighborhood health center programs and various public and private health and social welfare programs located in the area, such as Allegheny County's MN/MR centers, Child Welfare and Health Department.

With seven institutions providing a broad range of short-term acute care diagnostic and treatment services, the Northwest is generally well served in terms of availability and accessibility of these services. However, projections of inpatient bed need for this population indicates an excess of total beds needed to adequately serve the area. This situation is particularly evident in the Pittsburgh Northside area where three community hospitals serve a common patient population, which has resulted in low utilization and financially difficult operating conditions.

Utilization trends for the seven Allegheny Northwest hospitals show a slight decline in annual patient days over the past six year. In 1970, the seven hospitals experienced combined total patient days of 545,600 days, compared to the 1975 experience of 525,600 total patient days, a decrease of 3.7%. Individual trends show wide variation, with one hospital having gained 26,400 total annual patient days or 47% during this period while others decreased as much as 21,500 annual patient days, or approximately 30%.

Medical/Surgical occupancy rates have displayed a similar trend of overall decline in the past six years. Four hospitals have maintained average occupancy rates at or in excess of the 85% minimum recommended by the HSA's Adult Medical/Surgical Care Guidelines. However, three hospitals experienced significant declines in occupancy rates during the period and have not achieved an 85% annual Medical/Surgical occupancy rate since 1970. Not reflected in the occupancy rates of these three facilities are a total of 75 medical/surgical beds which are closed to use due to nonconformance with Life/Safety Code regulations or low patient census.

ST. JOHNS GENERAL HOSPITAL PLAN/PROGRAM FOR DEVELOPMENT

St. Johns' General Hospital, which was originally constructed in 1898, is presently functionally, physically and environmentally obsolete and has been cited for such deficiencies by the Joint Commission on Accreditation of Hospitals and the Pennsylvania Department of Labor and Industry. These conditions have caused a loss in operating efficiencies, have contributed to a decline in patient utilization at St. John's.

With the possible exception of a wing constructed in 1959, renovation of the present structure for continued patient service is neither architecturally nor economically practical. Therefore, if St. John's is to continue providing inpatient acute care services, replacement of the existing general hospital facilities would be required.

In October, 1976, St. John's General Hospital submitted for HSA review a plan to construct a new 180-bed facility to replace the existing, obsolete 192-bed general hospital. The new facility would be constructed on a site controlled by the hospital not far from the present hospital. The cost of the project was estimated at $26,150,000. Funds for the project would be obtained through Bond issue proceeds of $25,400,000 and fund raising of $750,000.

The HSA review of the St. John's General Hospital Plan/Program for Development encompassed an objective analysis of community need for services, staffing of the project, financial feasibility, and cost containment. Based on its analysis of these factors, the HSA concluded the following:

A. Community Need: The project correctly identified a community need for primary care, mental health care, inpatient psychiatric services, and an existing Alcohol and Drug Rehabilitation Center. However, the HSA's medical/surgical bed-need projection for 1985 indicated a current excess of approximately 260 beds in the Allegheny Northwest area. Therefore, the HSA concluded that the replacement of 120 medical/surgical beds was not necessary to meet the projected community need. Underutilized resources at nearby institutions, declining trends in patient days and average length of stay, and a declining population in the area, suggested that the hospital would not attain adequate utilization unless it was at the expense of other institutions.

B. Staffing: Analysis of an age profile of the present St. John's Medical staff, indicated that the hospital would probably need to replace part of its present medical staff in the near future in addition to the new physicians required. It was concluded that, even with a new hospital, St. John's would have difficulty attracting an adequate medical staff because of a lack of physician office space and limited financial resources.

C. Financial Feasibility: The HSA concluded that the project was marginally financially feasible and would have a negative impact on the community through increased costs for care, some of which increases would not be reimbursable under Blue Cross ceiling restrictions. Furthermore, the project's feasibility, as presented, was highly dependent on utilization projections which were inconsistent with historical trends in Allegheny Northwest and on expense projections which were felt to be unrealistic.

ST. JOHNS GENERAL HOSPITAL PLAN/PROGRAM FOR DEVELOPMENT (continued)

D. Cost Containment: The HSA concluded that the expenditure of $26 million could not be justified in terms of the potential cost to the community through: (a) costs that would be borne by needed services which do not require that a new hospital be built (i.e. ambulatory care and ADR); (b) the cost of maintaining potentially underutilized and duplicative resources (i.e. medical/surgical and emergency care); and (c) the total long-range cost of approximately $70 million associated with repayment of borrowed funds. The HSA was also concerned that the size of the proposed facility would not be large enough to foster economic efficiency. The HSA concluded that other, less costly, alternatives exist for the provision of the needed services and that other alternatives should be actively pursued.

As a result of its review, the HSA found that the St. John's project was not an acceptable plan for the future provision of the needed services. The HSA Board of Directors, therefore, recommended to the State Designated Planning Agency that the St. John's Plan/Program for Development not be endorsed and urged St. John's to consider other possible institutional roles and relationships within the Allegheny Northwest area.

In March, 1977, St. John's formally withdrew the project from the review process prior to State action in order to explore other alternatives. With HSA assistance, a joint planning effort has been established, involving St. John's and neighboring hospitals, to identify and describe reasonable alternatives for the provision of needed health services in Allegheny Northwest area.

SAN JOAQUIN MEDICAL FOUNDATION

(information supplied by SmithKline)

BRIEF SYNOPSIS AND HIGHLIGHTS OF THE MEDI-CAL MANAGEMENT AND UTILIZATION STUDY

This was a study of the effects of computerized utilization review, combined with peer review and other management techniques, in the San Joaquin Medical Foundation's administration of the Medicaid (Medi-Cal) program in its four member counties. Two other counties were used for comparison purposes. Comparisons and projections also have been made with statistical data covering the Medi-Cal program in the entire State of California.

Statistical tables and conclusions drawn from the study are the results of analyzing the records of Medi-Cal claims paid during a one year period in the six California Counties.

Typical of the findings and of particular interest were the following:

- The rate of increase in cost of services in the four Foundation counties (1976 to 1968) was significantly lower (3.7%), compared to the statewide increase of 13.8%.

- If the State's Medi-Cal expenditures had been at the same rate as that in the four San Joaquin Foundation Counties, where utilization review was functioning, the projected statewide expenditures would have been $117 million to $149 million less per year.

- In Kern County, the utilization rate for drugs, and the drug cost per eligible beneficiary, were significantly higher than in the other counties. But the cost of all health care services per eligible person was the lowest of the six counties at $22.21 per eligible person per month. While not conclusive, this suggests a possible relationship between high utilization of drugs (properly controlled but non-restrictive) and lower over-all costs of medical care, (hospital, nursing home, physician visits, etc.)

- Computerized claims processing and utilization review help to detect and eliminate duplicate payments. Shortening of the payment cycle (more prompt processing) through computerization and other improved management techniques tends to reduce duplicated claims. Possible duplicate claims found in the six counties during the study period amounted to 2.71% of total payments or approximately $855,000 in possible over-payments.

General observations and conclusions reached in the study include the following:

- Computerized utilization review, augmenting personalized professional review, promotes efficiency and minimizes unnecessary expenditures in medical assistance programs.

- Good internally controlled management information systems can greatly enhance the effective management of medical assistance programs.

- Abuses and improper payments can be the result of actions by the patient, the prescriber, the prescription dispenser, or the processor and payer of the claim. Because of the open-ended nature of Medicaid, controls, audits and utilization review are essential elements in administration of the program.

The thirty computer programs developed during the study for analysis of data and utilization review, along with necessary documentation for their installation, can be made available by the National Pharmaceutical Council to state medical assistance administrators for adoption in their programs.

MICHIGAN BLUE CROSS-BLUE SHIELD

The information which follows is quoted from Michigan BC-BS papers which were submitted by General Motors.

Any effort to impose a hospital price control should carefully study the Michigan program as a potential model. To the extent that they have been successful, they have had certain conditions (single insurance carrier dominance) and had to take certain actions (control of physician fee increases) that do not bode well for the success of a national effort.

By including this material in our Working Paper, we do not imply endorsement of the Michigan program. However, it is significant that this is a private sector initiative and one that clearly warrants scrutiny.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN HOSPITAL INPATIENT COST CAP PROGRAM
November 21, 1975

"GENERAL

"The interim hospital cost cap program will limit BCBSM reimbursement for hospital inpatient costs for the twelve month period from January 1, 1976, through December 31, 1976, to an amount not in excess of 10% over the calendar year 1975 level. The cost cap will be retrospectively applied to total allowable inpatient cost before apportionment. Allowable cost is defined as total inpatient expense less those amounts that are not recognized in the payment formula in accordance with BCBSM reimbursement policies.

"BASE PERIOD

"The base period for application of the cost cap will be the hospital's 1975 calendar year total allowable inpatient cost. This amount will be obtained from the regularly submitted BCBSM cost report for both the base and control years for hospitals with calendar year closing. Hospitals with fiscal years ending on March 31, June 30, and September 30 (including any others) will be provided the option of submitting additional BCBSM cost reports for the twelve month periods ending December 31, 1975 and 1976 in order to ensure a more accurate cut-off for computational purposes. In the event a non-calendar year hospital elects not to submit a calendar year cost report for these two periods, a combination of the regularly submitted cost reports and the BCBSM Quarterly Cost and Census Reports will be used to determine the base period and control year amounts.

"Hospital expenditures made during the fourth quarter (October through December) of 1975 will be examined to preclude a shifting of hospital expenditures from calendar year 1976 to the base period. Audit adjustments and expense accruals effected at the end of a hospital's fiscal year will be prorated by BCBSM over the entire accounting period, as appropriate. The control period (1976) and/or base period allowable cost will also be adjusted for the effect, if any, caused by (1) contracting out in 1976 certain services which were previously performed by the hospital's own staff, and (2) changing from commercial insurance coverage for professional liability risks to a self-insurance arrangement under which paid claims experience in 1976 could be minimal.

MICHIGAN BLUE CROSS-BLUE SHIELD (continued)

"VOLUME ADJUSTMENT

"Those hospitals which experience increased patient volume during 1976 (in comparison to 1975) will be allowed a volume adjustment intended to compensate for the increased costs resulting from a higher volume. The volume index used to measure inpatient volume changes is as follows:

$$\frac{\left[\frac{\text{1976 Admissions}}{\text{1975 Admissions}} + \frac{\text{1976 Patient Days}}{\text{1975 Patient Days}}\right]}{2}$$

"In the event application of this formula indicates that patient volume has decreased, rather than increased, from 1975 to 1976, no downward adjustment will be made to the allowable inpatient cost increase of 10%. For inpatient volume increases, the cost cap will be adjusted upward to reflect recognition of a 40% variable expense component related to the volume increase as determined by the preceding formula.

"PASS-THROUGHS

"In addition to the volume adjustment, hospitals will be allowed to pass-through for purposes of the cost cap the increased costs resulting from (1) higher professional liability insurance premiums (or, alternatively, paid claims experience where a hospital elects to self-insure) and (2) increased depreciation and interest expense relating to eligible capital expenditures. Capital projects will be considered eligible for the pass-through if:

"1. the project exceeds $100,000 in cost, and

"2. the project is approved under certificate of need, or

If the project is exempt from certificate of need, where there is either

A. Approval by the appropriate recognized areawide (314B) Comprehensive Health Planning Agency, or

B. Certification of eligibility under Section 1122 of Public Law 92-603.

"EXAMPLE

"The following example indicates the manner in which the cost cap will be determined for an individual hospital.

"FACTS

"I. Base Period — Calendar Year 1975

A.	Total allowable inpatient expense (before apportionment)	$10,000,000
	Includes: 1. Professional liability premiums	$ 250,000
	2. Depreciation & interest on eligible capital projects	$ 100,000
B.	Total patient days	60,000
C.	Total admissions	7,500

MICHIGAN BLUE CROSS-BLUE SHIELD (continued)

"II. Control Period — Calendar Year 1976

A.	Total allowable inpatient expense (before apportionment)	$11,500,000
	Includes: 1. Professional liability premiums	$ 500,000
	2. Depreciation & interest on eligible capital projects	$ 170,000
B.	Total patient days	61,800
C.	Total admissions	7,575

"The volume index would be computed as follows:

$$\frac{\left[\frac{\text{1976 Admissions}}{\text{1975 Admissions}} + \frac{\text{1976 Patient Days}}{\text{1975 Patient Days}}\right]}{2} = \frac{\left[\frac{7{,}575}{7{,}500} + \frac{61{,}800}{60{,}000}\right]}{2}$$

$$= \frac{1.01 + 1.03}{2} = 1.02 = \underline{2\%} \text{ Volume Increase}$$

"The 2% volume increase indicated above yields an allowable volume adjustment of $88,000, determined in the following manner:

2% Volume Increase x 40% Variable Expense Component x (1975 Total Allowable Inpatient Cost + 10%) = 2% x 40% x ($10,000,000 x 1.10%) = $88,000 Volume Adjustment

"The total inpatient cost increase permitted under the cost cap would therefore be:

1.	Basic Allowable Increase ($10,000,000 x 10%)	$1,000,000
2.	Volume Adjustment [(2% x 40% x ($10,000,000 x 1.10%)]	88,000
3.	Increase in P/L Premiums	250,000
4.	Increase in Depreciation/Interest Expense on Eligible Capital Expenditures ($170,000 - $100,000)	70,000
	Total Allowable Inpatient Cost Increase	$1,408,000

"In the event the hospital's actual inpatient cost increase was $1,500,000, the cost cap would be exceeded by $92,000 ($1,500,000 - $1,408,000), or 8/10 of 1% of 1976 total allowable inpatient expense ($92,000 ÷ $11,500,000). The BCBSM pro-rata portion of total allowable inpatient expense would then be reduced by 8/10 of 1% in recognition of the extent to which actual cost exceeds the cap amount.

"SETTLEMENT

After the cost cap limitation is determined in accordance with the procedure outlined above, BCBSM reimbursement will be made to the least of the following amounts:

1. Adjusted Cost (including the 2% inpatient and 6% outpatient Community Improvement Factors)

MICHIGAN BLUE CROSS-BLUE SHIELD (continued)

2. Contract Charges
3. Cost Increase Ceiling
4. Cost Cap

"APPEALS PROCEDURE

"A hospital may appeal a reduction in BCBSM reimbursement caused by application of the cost cap if that hospital is faced with extenuating circumstances or special conditions which warrant such consideration. The regular provider appeals procedure will be used for this purpose."

SUPPLEMENTAL INFORMATION - April 9, 1976

"GENERAL

"The Blue Cross and Blue Shield of Michigan (BCBSM) 10% limitation on increases in total allowable inpatient expense is effective for the twelve-month control year beginning January 1, 1976. The base year covers the twelve-month period from January 1, 1975, through December 31, 1975. The base and control year periods consist of these two calendar years, irrespective of an individual hospital's fiscal year. The 10% limitation applies only to inpatient cost increases; outpatient costs is not subject to the cap.

"Hospitals, not in operation for the entire twelve months of 1975, are not subject to the cap. Hospitals which were in operation for the entire year but began BCBSM participation after January 1, 1975, are subject to the cap.

"A cap limitation incurred by a non-calendar year hospital will be allocated between fiscal years, based on separate cost cap calculations for each fiscal year segment within the control year.

"INTERIM PAYMENT RATES

"BCBSM is currently reviewing the interim payment rate procedure to determine to what extent it should be modified in recognition of the cost cap program. Additional details will be provided when available.

"QUARTERLY REPORTS

"The BCBSM Quarterly Cost and Census Reports will be used in many cases by both the hospital and BCBSM to determine if the cost cap limitation has been exceeded. To preclude an inordinate shifting of hospital expenditures from 1976 to the base period, the hospital should exercise particular care in accounting for both the Quarterly Report and actual hospital expenditures for the fourth quarter of 1975.

"BASE/CONTROL YEAR ADJUSTMENTS

"If a hospital contracts out certain patient care services which previously had been performed by the hospital's staff, the base and/or control year will be adjusted for comparability. Removing physicians from cost as a result of changes

MICHIGAN BLUE CROSS-BLUE SHIELD (continued)

in billing and contractual arrangements would also require adjustment. Patient care services include radiology and pathology, for example, but not laundry, EDP operations, or similar non-patient care areas. If a hospital terminates a service, no adjustment will be made.

"VOLUME INDEX

"The volume index adjusts only for increases in hospital volume using the average increase in total patient days and total admissions from 1975 to 1976. The averaging process used in the index equally weighs both admissions and patient days.

"PASS-THROUGHS

"CAPITAL EXPENDITURES

"The cost cap program provides a pass-through for the inpatient portion of the net increase from 1975 to 1976 in depreciation and interest cost attributable to eligible capital projects. A project is considered eligible for this pass-through if the project equals or exceeds $100,000 in cost and is approved either under Certificate of Need, or if exempt from Certificate of Need, approved either by the appropriate Areawide (314B) Comprehensive Health Planning Agency or certified as eligible under Section 1122 of P.L. 92-603.

"If a hospital elects to lease, rather than purchase, equipment and/or other items as part of an eligible project, the equivalent depreciation and interest amounts will be imputed using the guidelines in the BCBSM Provider Reimbursement Manual chapter entitled "Rental and Leasing Costs." If this pass-through is utilized, interest and depreciation should be netted and removed from both the base and control year.

"If a net increase in depreciation and interest attributable to eligible capital projects is offset by a decrease in all other depreciation and interest, a pass-through will be made only for the amount by which the net increase from eligible projects offsets the decrease in all other depreciation and interest.

"PROFESSIONAL LIABILITY

The cost cap program also provides a pass-through for the inpatient portion of professional liability cost increases related either to commercial insurance premiums or paid claims if a hospital has elected a self-insurance arrangement. All professional liability expense will be removed from both the base and control years if there has been any change in either the commercial insurance or self-insurance arrangements.

"TENTATIVE COST CAP SETTLEMENT

"Tentative BCBSM cost cap settlement will incorporate the effect, if any, of the cost cap. For other than calendar year providers, the cost cap limit will be allocated between fiscal years on the basis of separate cost cap calculations for each fiscal year segment within the control year. If application of the cap limitation creates an overpayment due BDBSM, the overpayment recovery will proceed in accordance with the procedures discussed in the 'Reporting and Reimbursement' chapter of BCBSM Provider Reimbursement Manual.

MICHIGAN BLUE CROSS-BLUE SHIELD (continued)

"FINAL SETTLEMENT METHODS

"Hospitals with calendar year reporting periods will use the regularly submitted BCBSM cost reports for both the base and control years. Non-calendar year hospitals will submit either a detailed segregation of costs and offsets applicable to calendar years 1975 and 1976 or, if reasonable, use the appropriate BCBSM Quarterly Cost and Census Reports (subject to BCBSM audit) in conjunction with the regularly submitted BCBSM cost reports. Whatever method is used must apply to both the base and control years. As discussed at the Cost Reduction Program seminars, it will not ordinarily be necessary for a non-calendar year hospital to commit to one of these two methods until some time in mid-1977. In evaluating these methods, a hospital should weigh the benefits of increased accuracy resulting from making a detailed segregation of costs against the increased administrative cost and effort which that method would entail.

"OTHER LIMITATIONS

"The BCBSM interest, pension, and cost increase ceiling (CIC) limitations remain in effect. If a non-calendar year hospital is affected by the interest and/or pension limitation, it will be necessary to allocate the limitation between the base and control years to state total allowable cost properly for the two periods. The allocation procedure which has been developed provides that the interest limitation will be distributed on a monthly basis proportionate to actual allowable interest expense, and the pension limitation will be allocated proportionately by wage and salary expense. As additional experience is gained with the cost cap program and consideration is given to the circumstances involved in individual hospital cases, alternative allocation bases may be developed."

RESOURCES

In addition to the information provided throughout this Working Paper, several valuable references to people, organizations and materials came to our attention. They are listed here, in no special order, and this list will be updated periodically.

1. Greater Detroit Area Hospital Council, Inc.

   1900 Book Building, Detroit Michigan 48226 (313)963-4990

   Guidelines concerning hospital remodeling and replacement projects...published February 11, 1977.

2. Blue Cross-Blue Shield of Michigan

   Mr. Hallett Hall, Reimbursement Policy Coordinator (313)225-0213
   Program Development Unit J109
   600 Lafayette East, Detroit, MI 48226

   Primary source for information on the program described in the Appendix.

3. Michigan Department of Commerce, Insurance Bureau

   Thomas C. Jones, Commissioner of Insurance

   Notice of Hearing on Proposed Rules and Notice Thereof (No. 77-R-101)
   March 3, 1977

   "In the matter of rules relating to contracts between nonprofit hospital service corporations and participating hospitals."

   Contains very specific cost containment measures in five areas:

   1) number of hospital beds
   2) hospital utilization
   3) surgical screening
   4) laboratory and x-ray procedures
   5) incorrect and false billing

4. The Potential of Organizations of Fee-For-Service Physicians for Achieving Significant Decreases in Hospitalization by

   R.H. Egdahl, C.H. Taft, J. Friedland and K. Linde, Boston University Health Policy Institute, 53 Bay State Road, Boston, MA 02215

   "A study has been made of organizations of fee-for-service physicians which have provided care for their patients under an IPA-type HMO plan. Three IPA-type plans studied in detail achieved a striking decrease in hospitalization of their patients after introduction of the plan, or compared to a control population. Some of the important factors that appear to contribute to the decreased hospitalization were prepayment, involvement of some sharing of the financial risk by participating physicians, effectiveness of the peer review procedures, and high-quality management of the IPA-type HMO."

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NEW ENGLAND MEDICAL CENTER HOSPITAL

The Clinical Unit of the Tufts-New England Medical Center

Uniting the Boston Dispensary, Boston Floating Hospital for Infants and Children, and Pratt Clinic-New England Center Hospital

171 Harrison Avenue, Boston, Massachusetts 02111 Area code 617 482-2800

May 24, 1977

U.S. Senator Edward M. Kennedy
John F. Kennedy Federal Building
Boston, MA

Dear Senator Kennedy:

We are writing to you to express our opposition to the Carter Cost Control bill (HR6575/S1391) recently introduced by the administration. We are sure that you have already heard many objections to the bill, but we would like to express some of those that relate to New England Medical Center Hospital and hospitals in Boston in particular.

Control of One Segment of the Economy

First, it is grossly inappropriate to attempt to control one segment of the United States' economy without controlling those segments with which it deals. The hospital does not stand in isolation but purchases many supplies from various other commercial organizations. At our hospital we use normal business practices such as bidding, comparative analysis, etc. to attempt to develop the lowest cost for all services purchased, nevertheless the price trend for almost all goods over the past few years has been upward. In addition, there are some items, such as malpractice insurance and legal fees, which have experienced cost increases substantially above any generally recognized index because of particular problems and changes which relate solely to the hospital field. Other examples are the costs of fuel and food, which are necessities and yet to a great extent have their prices controlled external to the hospital.

Regional Problems

A second issue is the matter of regional approach to controls. Using one overall national index for controlling costs in Massachusetts, which has the highest cost of living in the continental United States, will only work against the economy in Massachusetts, as our hospitals will bear a heavier brunt of the controls than those hospitals in lower cost states. We read daily in the media of Massachusetts' problems with high unemployment and industry leaving the state. On the other hand, there are three industries that come quickly to mind that still are growth industries in the state, those being computer, education and medicine. With hospitals in Boston alone employing 38,000 people, any diminution of their ability to function and grow could eventually have a serious adverse affect on their employees and the numbers employed. This would only potentially add to the state's unemployment problem.

Intensity

I am sure you have heard the comments concerning the intensity in hospitals and that this is one of the reasons why costs tend to escalate faster than the consumer price index. We think two interesting statistics from our hospital's experience over the past two years would be indicative of what hospitals face in this regard. First, our intensive care units (ICU), which are the most expensive accommodations in the institution, have increased occupancy from 68% to 85% in two years. This is a 26% increase in the treatment of the most difficult illnesses. Another measure of our increasing intensity problem is the increase in our Medicare patients. Here again, in the same two years, the number of Medicare inpatients has increased 19%. It is generally considered that Medicare patients as a group are generally provided more care since by their nature their relative health when they enter the hospital is generally poorer than that of the general population. Both of these are factors over which the hospital has very little control. Under the hospital's long standing policy and the requirements of Hill-Burton free care and community service regulations, we do not refuse to treat anyone. These are only two instances of where the hospital's cost increases because it is treating more critically ill patients with no way in which to control the influx of such patients.

Expansion of Benefits

Another area where hospitals face an increasing change in their patient mix is where either voluntarily or by state mandate the health insurance benefits provided to residents of the state are expanded. In Massachusetts mandated coverage for alcoholism and mental health has been passed by the state legislature. Blue Cross has also expanded its benefits voluntarily over the past few years. Consequently more patients are seeking treatment in private hospitals as opposed to publicly operated hospitals forcing the latter to respond to a significantly increasing load of a different type of patients.

The state is also participating in deinstitutionalization of its mental health patients which adds a new burden of patients with mental illnesses who seek treatment in private hospitals.

Financing Mechanisms

Hospitals in Massachusetts are also forced to contend continually with chronic underfunding of the state's Medicaid program, which results in various mechanisms being used to reduce the cash flow to hospitals for patients they have legitimately treated who are the responsibility of the Commonwealth. State officials have admitted that the case load under Medicaid is increasing at 2% per year, nevertheless ignoring this and the effects of inflation, the Commonwealth constantly attempts to reduce the amount of funding for Medicaid. Thus hospitals are faced with treating more Medicaid patients with the same amount or less Medicaid funding. As you can well imagine these problems are most acute in the urban areas such as Boston where many areas are no longer served by private practitioners. Consequently these patients use hospital clinics for their primary care. In addition, the reduction of payments for general relief payments in 1975 only exacerbated the funding problem. In our hospital this has cost us over a half a million dollars per year in the last two years. Suffice it to say that with these types of underfunding we cannot survive financially with some aggregate rate limit put upon our rates charged to others.

Outpatient Services

Many hospitals participate in cross-subsidization of the outpatient services by inpatient services. This is done since persons using the hospital clinics generally are from the poor economic groups in society and cannot afford fees that would have to be charged in hospital outpatient departments to break even. As such the hospital provides a service to the local communities. The Carter bill limits on inpatient costs and charges could force hospitals into charging the full cost to outpatients such that many of those patients who honorably want to pay for their care would not be able to afford it. Since the limits imposed by the bill would also eliminate the source of charges to pay for the free care provided to many outpatients this could potentially result in many patients in Boston just not receiving care. Although some of the hospitals have large endowments that they might be able to fall back on there are many such as New England Medical Center that do not have substantial endowments and have always been forced to charge rates sufficient to cover operating costs.

Teaching Cost

Boston is a center for teaching hospitals, with its three medical schools. The Carter bill makes no provision for the increased costs of major teaching hospitals which, by their very nature, are involved in teaching, research and the development of improved techniques and procedures. This inevitably is more costly than the average community hospital. Without some special consideration for the funding of teaching hospitals we would have to voice the question of where physicians will train in the future.

Capital Limits

The capital expenditure limits in the Carter bill would cause even worse problems for Boston hospitals. Boston is a center of care for all of New England and much of this country. Thus to relate the number of beds in Boston to some local geographical limit is inappropriate since our service area far exceeds the boundaries of the city. For instance, our hospital for many years has been the prime referral center for the state of Maine under the Bingham program which was a prototype for the Hill-Burton program passed by Congress in the late 1940's.

This capital limit is also unfair to those hospitals which have planned carefully and taken a fiscally responsible approach to financing new facilities to make sure that they proceeded appropriately. It benefits those hospitals who did not proceed in this manner. In our own case, our trustees have continually monitored our planning, such that the hospital did not become financially unsound through inappropriate building. Nevertheless we could now be penalized in our facility development because of this responsible approach. This could result in Boston and New England eventually losing one of its principal tertiary care centers.

We further see no inclusion in the proposed law to include the cost of financing major facility additions in operating costs as an exception. Generally no hospital today can participate in a major expansion without increasing its operating costs, at least on a one-time basis. This could cause uncertainty in the bond market which could have the effect of raising bond interest rates and consequently hospital operating costs.

Summary

In summary, we hope these comments have given you some insight into how the Carter bill would affect one major teaching hospital in Boston. Much of what we have stated is applicable to other Boston hospitals. Thus we seek your support in opposition to the Carter proposal as an unsound, unrealistic bill which would adversely affect the hospitals in Boston and Massachusetts.

Furthermore, the Carter bill seems to ignore a lot of the hard and careful work done by the Senate Finance Committee and the House Ways and Means Committee over the past years in the area of controls on hospitals and on the health system. A good example is the bill recently submitted by Senator Talmadge which is a far more thoughtful approach to a complex subject than is the administration's simplistic and yet unworkable proposal.

Sincerely,

Lawrence A. Hill
Executive Director

LAH:gm

cc: Stephen J. Hegarty, Director Health Care Finance, MHA
Alex McMahon, President, AHA

COUDERT BROTHERS
ATTORNEYS AND COUNSELLORS AT LAW
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May 27, 1977

Senator Edward M. Kennedy
431 Senate Office Building
Washington, D.C. 20510

Dear Senator Kennedy:

Thank you very much for your letter of April 11, 1977 regarding possible effects of the proposed hospital cost-containment legislation on the adoption of potentially cost-containing technology such as hospital information systems.

Unfortunately, it now appears that the proposed Hospital Cost Containment Act of 1977 has the danger of discouraging the exploitation of this promising technology. In particular, Section 1504 of Title II, Limitation on Hospital Capital Expenditures would place a ceiling upon capital expenditures by hospitals without regard to whether the long-term effect of such expenditures might be to reduce the costs of quality health care.

As you know from your interest in medical information systems, exemplified by your tasking OTA to study the policy implications of such systems, there is a growing body of evidence that such systems do indeed have the potential to help slow the hospital cost spiral. Of course it is entirely possible that there may be other technologies, either presently known or unknown, which may have the same or similar potentials. Accordingly, it is strongly urged that Section 1504 be amended to include a specific exemption for capital expenditures which are necessary to facilitate an experiment, demonstration or evaluation consistent with the purposes of Title II. Thus Section 1504(a)(2) should be amended by the addition at its conclusion of the following sentence:

A capital expenditure may be excluded from the application of this Title if the Secretary determines that such exclusion is necessary to facilitate an experiment, demonstration or evaluation consistent with the purposes of this Title.

As you know, the language suggested above simply tracks the language of Section 118 of Title I; that Section excludes from the revenue limitation experiments and demonstrations by hospitals attempting to reduce their revenue requirements.

I am deeply grateful for any time and attention you may be able to devote to preventing the "Catch-22" of discouraging hospital investment in cost containing technology in a bill whose purpose is to help contain costs.

Dr. Shapiro and I have already briefly discussed this amendment and I would of course be happy to provide any additional information which may be helpful.

With kind regards,

Sincerely,

Sherman E. Katz

SEK/mz

cc: Dr. Stuart Shapiro

March 17, 1977

Senator Edward M. Kennedy
431 Senate Office Building
Washington, D.C. 20510

Dear Senator Kennedy:

As you know, the Secretary of Health, Education and Welfare Joseph Califano has announced the intention of his Department to propose legislation for the establishment of hospital budget ceilings to be reviewed and enforced by D/HEW. The purpose of such legislation would be to help curb the currently unacceptable rate of inflation of the cost of hospital care.

One potential drawback to this plan is that it may inadvertently discourage hospitals from procuring hospital information systems which have the potential to help hospitals contain costs. As you will note from the enclosed copy of my letter to Dr. Karen Davis, I have attempted to alert D/HEW to this possible "Catch-22." In particular, an HEW-supported independent evaluation, conducted by Battelle Laboratories, of the Technicon Medical Information System at its first installation at the El Camino Hospital in Mountain View, California, conducted over four years at a cost the Federal government of $1.5 million, indicates that the System "had a demonstrably favorable impact on the organization and administration" of the hospital. The Hospital's own study indicates that the System is making possible a saving of approximately $40,000 per month after payment of a System rental fee of $83,000 per month.

As you will also note from my letter to Dr. Davis, Battelle recommended that this type of System "should be demonstrated and evaluated in other hospitals, such as large urban hospitals and Federal hospitals, to determine. . .the extent to which benefits realized at El Camino Hospital may also be realized in other hospital environments." In view of the dramatically

favorable results of the initial evaluation of this technology, it would indeed be ironic if the proposed plan for hospital budget ceilings either made it impossible or discouraged hospitals from investing in this type of potential cost-containing technology.

One solution we have suggested to Dr. Davis is that specific provisions be made to permit a given number of hospitals to make such investments. Moreover, in the light of the growing Federal share of hospital costs, it may be appropriate for some incentive for such investments to be provided such as Federal payment of a portion of the sometime overwhelming obstacle of the initial capital investment. If the Battelle evaluation is any indicator, the long-term return on this hhared investment would be significant progress toward contained costs.

Of course I am hopeful that D/HEW will take account of this suggestion in its proposal. Nonetheless, I wanted you to be aware of the problem in the event it escapes the attention of the proper persons at HEW.

As counsel to Technicon, I would of course be happy to provide additional information if you think it would be helpful. In any event I would be deeply grateful for your reaction.

With kind regards,

Sincerely,

Sherman E. Katz

SEK/mz

Enclosure

cc: Stanley Jones

Loeb Rhoades & Co. Inc.
Forty Two Wall Street, New York, N.Y. 10005
Telephone 212 483-6000

LOEB RHOADES

May 18, 1977

SPECIAL DELIVERY

Dr. Stuart Shapiro
Professional Staff Member
Subcommittee on Health of Senate
Human Resources Committee
Room 310B
Senate Courts Annex
Washington, D.C. 20510

Dear Stuart:

I enjoyed meeting with you last week and exchanging ideas regarding the health care delivery system. As you know, my involvement in health care financing and financial advisory work has been over a period of nine years. I thought I might restate in written form the suggestion I made regarding reimbursement for capital development programs.

I suggest that any hospital proposing a development project, after satisfying the "need" requirements in each category of service, be assured that the debt expenditure both amortization and interest will be fully reimbursed. Currently, the reimbursement mechanism pays for interest expense and straight-line depreciation. The reimbursers, Medicare, Medicaid, Blue Cross etc., must undertake that as long as projected utilization is met within some acceptable "bands" the Hospital will be fully reimbursed for "the average cost of the service" as determined on a basis which compares hospital size, geography and services. The difference to the third party payor between the two mechanisms of reimbursement for interest and depreciation or interest and amortization on a level debt basis can be illustrated by a simple example:

Assume a $20,000,000 capital improvement program with an estimated average life of the building and the equipment of 20 years, a net interest cost of 7% over a 25 year debt term. Also included as an example of the need to review interest

costs is the same borrowing at 9% net interest cost. See attached for examples.

As can be seen on a level debt basis, a much lower formula for reimbursement for a development program would result in using the new method. This plan, however, can only work prospectively since to take away historical depreciation would be too great a burden for the hospital industry.

In addition, it would be necessary under this scheme to also provide a level of reimbursement at say 10% for invested capital or equity in the development which will allow a sufficient return for future modernization and improvements as well as an incentive for charitable contribution. For every charity dollar invested in a development program under the proposed plan the reimburser saves all the cost both interest and depreciation. Also, this return of invested capital would have the virtue of encouraging the use of contributed funds in all projects since the hospital would realize a return on its equity.

Finally, as part of the plan and to make the plan more effective a National Council with authority to review the effective interest cost of a project should be instituted. Its role would be to make sure the lowest net interest cost is achieved. As illustrated by the 9% example this also would have an enormous effect on reimbursement costs. Today, the spread in interest costs toward lower cost is in no way encouraged or penalized by our reimbursement system.

I look forward to discussing this brief outline further with you at your convenience.

Sincerely,

David H. Troob
First Vice President

DHT:se

MORTGAGE LOAN REPAYMENT SCHEDULE
(Payments Made Every Month)

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LOAN REQUIREMENTS

Date Mortgage Loan was Made	12/1977
Amount Borrowed	$20,000,000.00
Amount of Each Payment	$141,355.84
Number of Payments	300
Rate of Interest Charged	7.000%
Total Interest to be Paid	$22,406,752.00
Total Principal and Interest Paid	$42,406,752.00

Year	(B) Principal Repayment	(C) Depreciation Expense*	(D) Difference Between Principal Repayment** and Depreciation Expense	(E) Interest	(F) Ending Principal Outstanding	(G) Total Repayment
1978	305,962.65	1,000,000.00	694,037.35	1,390,307.43	19,694,037.35	1,696,270.08
1979	328,080.75	1,000,000.00	671,919.25	1,368,189.33	19,365,956.60	1,696,270.08
1980	351,797.74	1,000,000.00	648,202.26	1,344,472.34	19,014,158.86	1,696,270.08
1981	377,229.23	1,000,000.00	622,770.77	1,319,040.85	18,636,929.63	1,696,270.08
1982	404,499.15	1,000,000.00	595,500.85	1,291,770.93	18,232,430.48	1,696,270.08
1983	433,740.45	1,000,000.00	566,259.55	1,262,529.63	17,798,690.03	1,696,270.08
1984	465,095.55	1,000,000.00	534,904.45	1,231,174.53	17,333,594.48	1,696,270.08
1985	498,717.38	1,000,000.00	501,282.62	1,197,552.70	16,834,877.10	1,696,270.08
1986	534,769.67	1,000,000.00	465,230.33	1,161,500.41	16,300,107.43	1,696,270.08
1987	573,428.20	1,000,000.00	426,571.80	1,122,841.88	15,726,679.23	1,696,270.08
1988	614,881.39	1,000,000.00	385,118.61	1,081,388.69	15,111,797.84	1,696,270.08
1989	659,331.21	1,000,000.00	340,668.79	1,036,938.87	14,452,466.63	1,696,270.08
1990	706,994.31	1,000,000.00	293,005.69	989,275.77	13,745,472.32	1,696,270.08
1991	758,103.01	1,000,000.00	241,896.99	938,167.07	12,987,369.31	1,696,270.08
1992	812,906.33	1,000,000.00	187,093.67	883,363.75	12,174,462.98	1,696,270.08
1993	871,671.39	1,000,000.00	128,328.61	824,598.69	11,302,791.59	1,696,270.08
1994	934,684.59	1,000,000.00	65,315.41	761,585.49	10,368,107.00	1,696,270.08
1995	1,002,253.01	1,000,000.00	(2,253.01)	694,017.07	9,365,853.99	1,696,270.08
1996	1,074,705.96	1,000,000.00	(74,705.96)	621,564.12	8,291,148.03	1,696,270.08
1997	1,152,396.54	1,000,000.00	(152,396.54)	543,873.54	7,138,751.49	1,696,270.08
1998	1,235,703.38			460,566.70	5,903,048.11	1,696,270.08
1999	1,325,032.47			371,237.61	4,578,015.64	1,696,270.08
2000	1,420,819.18			275,450.90	3,157,196.46	1,696,270.08
2001	1,523,530.31			172,739.77	1,633,666.15	1,696,270.08
2002	1,633,666.15			62,603.93	0.00	1,696,270.08
		20,000,000.00				

*Depreciation calculated using the straight-line method over 20 years.

**The future value of this income stream subtracting negative results for years 1995-1997 accumulated at a 6% return on investment = $14,292,596.

1800

MORTGAGE LOAN REPAYMENT SCHEDULE
(Payments Made Every Month)

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LOAN REQUIREMENTS

Date Mortgage Loan was Made.....	12/1977
Amount Borrowed.....	$20,000,000.00
Amount of Each Payment.....	$167,839.27
Number of Payments.....	300
Rate of Interest Charged.....	9.000%
Total Interest to be Paid.....	$30,351,781.00
Total Principal and Interest Paid.....	$50,351,781.00

Year	Principal Repayment	Depreciation Expense*	Difference Between Principal Repayment** and Depreciation Expense	Interest	Ending Principal Outstanding	Total Repayment
1978	223,126.20	1,000,000.00	776,873.80	1,790,945.04	19,776,873.80	2,014,071.24
1979	244,056.98	1,000,000.00	755,943.02	1,770,014.26	19,532,816.82	2,014,071.24
1980	266,951.22	1,000,000.00	733,048.78	1,747,120.02	19,265,865.60	2,014,071.24
1981	291,993.09	1,000,000.00	708,006.91	1,722,078.15	18,973,872.51	2,014,071.24
1982	319,384.05	1,000,000.00	680,615.95	1,694,687.19	18,654,488.46	2,014,071.24
1983	349,344.48	1,000,000.00	650,655.52	1,664,726.76	18,305,143.98	2,014,071.24
1984	382,115.40	1,000,000.00	617,884.60	1,631,955.84	17,923,028.58	2,014,071.24
1985	417,960.47	1,000,000.00	582,039.53	1,596,110.77	17,505,068.11	2,014,071.24
1986	457,168.03	1,000,000.00	542,831.97	1,556,903.21	17,047,900.08	2,014,071.24
1987	500,053.53	1,000,000.00	499,946.47	1,514,017.71	16,547,846.55	2,014,071.24
1988	546,962.03	1,000,000.00	453,037.97	1,467,109.21	16,000,884.52	2,014,071.24
1989	598,270.82	1,000,000.00	401,729.18	1,415,800.42	15,402,613.70	2,014,071.24
1990	654,392.76	1,000,000.00	345,607.24	1,359,678.48	14,748,220.94	2,014,071.24
1991	751,779.31	1,000,000.00	284,220.69	1,298,291.93	14,032,441.63	2,014,071.24
1992	782,924.36	1,000,000.00	217,075.64	1,231,146.88	13,249,517.27	2,014,071.24
1993	856,368.04	1,000,000.00	143,631.96	1,157,703.20	12,393,149.23	2,014,071.24
1994	936,701.27	1,000,000.00	63,298.73	1,077,369.97	11,456,447.96	2,014,071.24
1995	1,024,570.34	1,000,000.00	(24,570.34)	989,500.90	10,431,877.62	2,014,071.24
1996	1,120,682.10	1,000,000.00	(120,682.10)	893,389.14	9,311,195.52	2,014,071.24
1997	1,225,809.80	1,000,000.00	(225,809.80)	788,261.44	8,085,385.72	2,014,071.24
1998	1,340,799.22			673,272.02	6,744,586.50	2,014,071.24
1999	1,466,575.42			547,495.82	5,278,011.08	2,014,071.24
2000	1,604,150.32			409,920.92	3,673,860.76	2,014,071.24
2001	1,754,630.68			259,440.56	1,919,230.08	2,014,071.24
2002	1,919,230.08			94,841.16	0.00	2,014,071.24
		20,000,000.00				

* Depreciation calculated using the straight-line method over 20 years.

** The future value of this income stream subtracting negative results for years 1995-1997 accumulated at a 6% return on investment = $16,248,351.

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